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Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Veterans Health Administration's Multi-Tiered Patient Safety Program

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Executive Summary

The VA Office of Inspector General (OIG) conducted a review of Veterans Health Administration's (VHA) Patient Safety Program to assess oversight, culture of safety, staffing, and training. This report stems from OIG's concerns regarding the ability of VHA to promote and support patient safety initiatives with current processes and program structure. A lack of VHA oversight of factors affecting patient safety has been a recurring theme in recent OIG report publications (see appendix A).[1]

Patient safety, as defined by the World Health Organization, "is the prevention of errors and adverse effects to patients associated with health care."[2] "Establishing cultures, processes, procedures, behaviors, technologies, and environments in health care" that focus on patient safety "lowers risks of patient harm and reduces the incidence of errors."[3]

VHA Patient Safety Program

VHA's Patient Safety Program uses systematic and multi-tiered approaches to improving patient safety that include understanding and exploring system vulnerabilities that can result in patient harm, reporting of adverse events or close calls, and emphasizing prevention rather than punishment to reduce patient harm.[4] VHA's Patient Safety Program has functions within VHA's Office of the Deputy Under Secretary for Health, Veterans Integrated Service Networks (VISNs), and medical facilities (facilities). VHA established the National Center for Patient Safety (NCPS) in 1999 "to lead VA's patient safety efforts" with the primary goal of reducing and preventing patient harm resulting from medical care.[5] NCPS is within the VHA Office of the

[1] During the three-year period of July 1, 2019, through June 30, 2022, 23 percent (31 of 135) of OIG published hotline healthcare inspection reports and 22 percent (29 of 134) of comprehensive healthcare inspection reports had at least one recommendation related to VHA's Patient Safety Program.

[2] "Patient Safety," World Health Organization, accessed January 31, 2023, https://www.who.int/europe/health-topics/patient-safety#tab=tab_1.

[3] "Patient Safety," World Health Organization, accessed January 3, 2023, https://www.who.int/health-topics/patient-safety/#tab=tab_1. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[4] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This handbook was in effect at the time of the review until it was rescinded and replaced by VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. Unless otherwise specified, the two policies contain similar language related to VHA's Patient Safety Program. For the purposes of this report, "VHA Patient Safety Program" refers to the VHA, VISN, and facility patient safety programs.

[5] "About Us," VA, National Center for Patient Safety, accessed October 20, 2022, https://dvagov.sharepoint.com/sites/vhancps/SitePages/About-us.aspx. VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks. (This site is not publicly accessible.)

Deputy Under Secretary for Health's Office of Quality and Patient Safety. Significantly, NCPS does not have any independent authority over VISNs or facilities.

VHA's Office of the Under Secretary for Health publishes the VHA National Patient Safety Improvement Handbook and annual requirement memoranda, which outline facility requirements to achieve VHA's Patient Safety Program goal of preventing harm to patients.[6] These requirements consist of the identification of patient safety events, patient safety event reporting, and completion of a minimum of eight patient safety analyses annually, including root cause analysis (RCA), proactive risk assessments, and patient safety assessment tool evaluations.

Key leaders who support patient safety efforts include VISN patient safety officers (PSO), who are accountable to VISN network directors. As part of VISN patient safety programs, PSOs should conduct facility patient safety program reviews, and have oversight over facility patient safety programs including monitoring the quality and progress of patient safety analyses and actions, and tracking and trending patient safety events reported across their VISN.[7] VISN PSOs do not have any specific authority over facility patient safety programs.[8] VHA policy establishes that facility patient safety programs, managed and overseen by patient safety managers (PSM), are aligned under facility directors.[9] PSMs are responsible for several program duties, including determining the response and actions following the reporting of patient safety events and managing patient safety alerts and patient safety advisories.[10] In addition, VHA policy designates

[6] VHA Handbook 1050.01; VHA Directive 1050.01; VHA Deputy Under Secretary for Health for Organizational Excellence, "Annual Minimum Requirements for Facilities to Perform Patient Safety Analyses," memorandum to VISN Directors (10N1–23), March 17, 2020; VHA Assistant Under Secretary for Health for Quality and Patient Safety, "Annual Minimum Requirements for Facilities to Perform Patient Safety Analyses," memorandum to VISN Directors (10N1–23), April 25, 2022. The 2020 and 2022 memoranda provided clarification on the annual requirement for patient safety analyses. VHA Directive 1050.01 rescinded the 2022 memorandum but maintained the annual analyses requirement. The directive also describes reporting adverse events as a VHA Patient Safety Program foundational principle and outlines a requirement for reporting patient safety events.

[7] *VHA National Center for Patient Safety Guidebook for Completing Facility Patient Safety Program Reviews*, October 2021; "VHA VISN XX Network Functional Statement Patient Safety Officer Nurse IV," NCPS SharePoint, accessed June 22, 2022, https://dvagov.sharepoint.com/sites/vhancps/Shared%20Documents/Forms/Internal.aspx?id=%2Fsites%2Fvhancps%2FShared%20Documents%2FPatient%20Safety%20Professionals%20Position%20and%20Mentoring%20Resources%2FFunctional%20Statements%2FPatient%20Safety%20Officer%2FExample%20VHA%20Patient%20Safety%20Officer%5FFS%5FNurse%20IV%2Epdf&parent=%2Fsites%2Fvhancps%2FShared%20Documents%2FPatient%20Safety%20Professionals%20Position%20and%20Mentoring%20Resources%2FFunctional%20Statements%2FPatient%20Safety%20Officer. PSO responsibilities were identified in this sample description of duties.

[8] VHA Directive 1050.01. The directive states that PSO responsibilities include "serving as the principal advisor for each VA medical facility in the VISN and facility leadership."

[9] VHA Handbook 1050.01; VHA Directive 1050.01. Based on review of VHA Handbook 1050.01, the OIG found no written policy for the facility patient safety program to be in alignment under the facility director; however, VHA Directive 1050.01 references the alignment of the patient safety program under the facility director.

[10] VHA Handbook 1050.01; VHA Directive 1050.01. VHA Directive 1050.01 includes additional PSM responsibilities as compared to VHA Handbook 1050.01. The PSM has responsibility for implementing and monitoring patient safety improvements related to facilities' required patient safety analyses.

the facility director to be responsible for ensuring completion of facility patient safety program requirements, including the eight annual patient safety analyses.[11]

Review Methodology and Results

The OIG conducted a national survey of facility PSMs (PSM survey) and a separate survey of VISN PSOs (PSO survey). Both surveys focused on similar patient safety topics reported in previous OIG or NCPS reports, including oversight, culture, staffing, and training. Of the surveys received, 87 percent of PSMs (184) and 89 percent of PSOs (16) responded.[12] The OIG also conducted interviews with the Assistant Under Secretary for Health for Quality and Patient Safety and the NCPS Executive Director to understand the mission, vision, and goals of VHA's Patient Safety Program, and 18 PSOs to assess their responsibilities and oversight of facility patient safety programs.[13] Further, the OIG reviewed relevant VHA policies, guidelines, and other administrative reports related to patient safety.

Based on the analysis of the survey results and interview information, the OIG found variabilities in NCPS and VISN oversight of facility patient safety programs and facility patient safety program staffing. Additionally, VISN and facility staff identified barriers to fostering a strong safety culture and providing standardized patient safety training.

Oversight of VHA Patient Safety Programs

NCPS provides direction and guidance to VHA about policies and strategies to "measure and mitigate harm to the [patient] and those who support their care."[14] During an interview with the OIG, when asked if NCPS was to be consultative, provide oversight, or both, the NCPS Executive Director responded "we [NCPS] hold people to standards" and "are here to set a standard."

NCPS develops quarterly reports, which contain facility patient safety analyses data collected from the Joint Patient Safety Reporting (JPSR) system, SPOT, and other VHA data sources.[15]

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[11] VHA Handbook 1050.01; VHA Directive 1050.01.

[12] The OIG did not receive completed survey responses from 27 facility PSMs and two VISN PSOs. The OIG did not grant extensions. The OIG utilized the survey as the sole data source for PSMs and analyzed the completed responses from 184 PSMs at 132 facilities.

[13] The OIG determined the PSM survey response rate was representative of the PSM experiences and did not conduct PSM interviews.

[14] "Quality and Patient Safety," VHA Office of Quality and Patient Safety, accessed July 5, 2022, https://vaww.qps.med.va.gov/default.aspx. (This site is not publicly accessible.)

[15] "VHA NCPS Patient Safety Quarterly Report Interpretation Document, Fiscal Year 2022 Quarter 2," September 8, 2022. VHA Handbook 1050.01; VHA Directive 1050.01. VHA Deputy Under Secretary for Health for Organizational Excellence, "Annual Minimum Requirements for Facilities to Perform Patient Safety Analyses," memorandum. VHA Assistant Under Secretary for Health for Quality and Patient Safety, "Annual Minimum Requirements for Facilities to Perform Patient Safety Analyses," memorandum.

Quarterly reports also include VISN and national level comparisons of patient safety event data and completion of patient safety analyses requirements. According to NCPS, quarterly reports are "intended to promote safety, quality, standardization, increased event reporting and high reliability."[16]

The OIG determined that while the quarterly reports included patient safety program data such as volume of JPSR events reported and patient safety analyses completed, they did not provide a qualitative analysis of patient safety data. For example, the quarterly reports referenced the number of adverse events but did not include an analysis of actions initiated in response to adverse events.[17]

The OIG developed survey questions to understand patient safety staff review and application of the information provided in these reports. Notably, 10 percent (18) of PSMs' survey responses indicated they do not receive the quarterly reports. When asked "How do you use the report in your job?" 9 percent (14 of 154) of PSMs who reported receiving quarterly reports answered, "report not used." When asked to further explain reasons the reports were not utilized, PSMs indicated in survey comments that the reports are not received timely, are too lengthy, or are not meaningful or useful. In addition, report data was already accessible from the JPSR system, or outside the scope of the facility patient safety program. Further, PSMs noted there was a lack of understanding on how to interpret the data.

During an interview, the VHA's Assistant Under Secretary for Health for Quality and Patient Safety told the OIG of streamlining the quarterly reports to make the quarterly reports more useful to staff who receive the reports. The NCPS Executive Director explained changes were made to the reports, which included making the reports shorter, providing the reports more timely, adding visualizations and charts, and explaining report data.[18]

The OIG agrees that a shift to include an analysis of patient safety data in the quarterly reports would be helpful to staff. A focus on using data to drive process changes can lower or have potential to lower the risk of patient harm.

The *VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance* states that VISN PSOs are responsible for overseeing that facilities monitor and investigate JPSR

[16] "VHA NCPS Patient Safety Quarterly Report Interpretation Document, Fiscal Year 2022 Quarter 2."

[17] During this review, the OIG evaluated a sample of NCPS quarterly reports from fiscal year 2021.

[18] In October 2022, an NCPS staff member provided a second quarter fiscal year NCPS quarterly report to the OIG. The OIG noted additional visualizations and charts in the report as compared to fiscal year 2021 quarterly reports. The same staff member provided "VHA NCPS Patient Safety Quarterly Report Interpretation Document," which included report data explanations.

events and that PSOs "will review a subset of all [JPSR] event reports" but does not define the frequency or volume of the reviews required.[19]

During interviews, the OIG found that although all PSOs reported having processes to provide oversight of the implementation and quality of facility patient safety programs within each VISN, there was variability in oversight practices, which include the frequency and volume of reviews required.

Oversight of Community Care Patient Safety

Under the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, veterans can receive care in the community through a network of providers managed by third-party administrators.[20] VHA guidance indicates that PSOs should communicate and coordinate with third-party administrators' quality and patient safety representatives and provide "input and guidance on RCA corrective outcomes if applicable."[21] Additionally, NCPS encourages PSOs and PSMs to communicate with third-party administrators when adverse events involving care in the community occur to ensure an analysis is completed.[22]

The OIG surveyed PSOs to determine whether they meet with third-party administrators' quality and patient safety representatives. Six PSOs responded *yes*, while 10 PSOs responded *no*. PSOs stated that barriers to meeting with third-party administrators included inconvenient meeting times, not being included in meeting invitations, and third-party administrators not agreeing to or declining to meet. During interviews, all PSOs indicated there are processes in place to report quality and safety concerns to third-party administrators. Some PSOs reported feedback from the third-party administrators is limited to whether the review of concerns is in progress or complete. A PSO stated the process is "uncomfortable. . . [because PSOs] have to make sure [third-party administrators are] following upon safety events. . . we can't see [third-party administrators'] RCA. . . but we have to somehow have confidence that they are doing [RCAs]."

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[19] *VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance*, November 2021. The rules discussed in this report are also covered by the VHA National Center for Patient Safety JPSR Business Rules and Guidebook, July 2020, and VA National Center for Patient Safety Joint Patient Safety Reporting (JPSR) System Business Rules, May 1, 2018. The three versions contain similar language related to the basic role of the PSO; the 2021 version contains additional details. Unless otherwise noted, the November 2021 version is referenced throughout this report.

[20] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 § 505 (2018). VHA, "Community Care Network (CCN) Fact Sheet," updated January 21, 2022.

[21] Veterans' Health Administration Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook, February 2022.

[22] Veterans' Health Administration Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook.

Culture of Safety

The Joint Commission defines safety culture within a healthcare system as a reflection of all staff's "beliefs, values, attitudes, perceptions, competencies and patterns of behavior that determine the organization's commitment to quality and patient safety."[23] In organizations with a strong safety culture, there is a "commitment to safety" and to "do no harm."[24] In an effort to further cultivate a culture of safety, VHA began a journey to implement high reliability organization principles in February 2019.[25]

The OIG surveyed PSMs and PSOs to understand their perceptions of how patient safety is prioritized within their organizations.[26] Of the 184 PSMs who responded to the survey, 76 percent (139) of PSMs *agreed* or *strongly agreed* when asked if patient safety is an organizational priority considered during decision-making processes. Additionally, PSOs were asked to rate their agreement with the statement "Patient safety is a VISN priority that is considered in decision-making processes." Twelve of the 16 PSOs who responded to the survey either *agreed* or *strongly agreed* with the statement.

The OIG also surveyed PSMs to determine whether they felt supported by facility executive leadership teams when adverse events occur.[27] Approximately 80 percent (145) *agreed* or *strongly agreed* that facility executive leaders provided the necessary support. PSMs who did not agree were asked to provide further explanation and identified a lack of direct or limited contact with executive leaders. This limited communication may inhibit PSMs' ability to build trusted relationships if left unaddressed by facility leaders. As VHA continues its high reliability organization journey and implementation of a culture of safety, the OIG would expect VISN and facility leaders to consistently place patient safety as a priority and engage PSMs and PSOs in discussions and decisions related to patient safety.

Patient Safety Program Staffing

The Joint Commission reports that insufficient staffing and excessive workload contributes to staff fatigue in the healthcare setting.[28] In addition, the COVID-19 pandemic has placed

[23] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, E-dition, July 1, 2022, "Patient Safety Systems (PS)," accessed October 21, 2022, https://e-dition.jcrinc.com/MainContent.aspx.

[24] Comprehensive Accreditation Manual for Hospitals, E-dition. "Patient Safety Systems (PS)."

[25] VHA, "High Reliability Organization (HRO) Fact Sheet," September 2021.

[26] "Organization" refers to the facility or VISN.

[27] The OIG defined an executive leadership team to include a facility director, chief of staff, associate director, and associate director for patient care services/nurse executive. The OIG recognizes that facilities may have variations of an executive leadership team.

[28] The Joint Commission, "Health Care Worker Fatigue and Patient Safety," *Sentinel Event Alert* 48 (December 14, 2011, addendum May 14, 2018).

additional strain on a healthcare workforce already faced with existing shortages and "significant problems" with burnout and stress.[29]

The OIG evaluated facility and VISN patient safety program staffing through the PSM and PSO survey responses and interviews, VHA policy, and documents received from NCPS. The OIG also evaluated the effect of facility patient safety program staffing and ability to meet VHA Patient Safety Program requirements.

Facility Patient Safety Program Staffing

VHA policy establishes that PSMs are responsible for several program duties within the framework of a facility patient safety program.[30] However, at the time of the survey, based upon review of VHA Handbook 1050.01, the OIG found no written guidelines for the number of patient safety program staff required at facilities or that a PSM was a designated full-time equivalent position.[31]

The OIG found that all facilities with survey responses were staffed with at least a PSM and some facilities had additional patient safety staff assigned.[32] However, in written comments to the survey, PSMs described having minimal administrative support to manage a facility's patient safety program as well as other assignments outside of patient safety such as assisting with implementation of their facility's high reliability organization program. Respondents also indicated that inadequate staffing had a negative impact on PSMs' ability to fulfill patient safety program requirements, such as JPSR event management and follow-up and RCA completion.[33]

[29] Assistant Secretary for Planning and Evaluation, Office of Health Policy, *Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce*, HP-2022-13, May 3, 2022.

[30] VHA Handbook 1050.01; VHA Directive 1050.01.

[31] VHA Handbook 1050.01; VHA Directive 1050.01. The directive states that the facility director is responsible for assigning a minimum of one full-time equivalent PSM position.

[32] The OIG surveyed 211 PSMs in 138 out of 139 official facilities. The Joseph Maxwell Cleland Atlanta VA Medical Center PSM position was reported as vacant during the survey period and was not included in the survey. The OIG obtained survey responses from 184 PSMs in 132 facilities. The OIG used the survey responses to determine the status of additional patient safety staff other than a single PSM for each facility. If the facility had more than one PSM or the surveyed PSM indicated that there were additional staff assigned to the patient safety program, the OIG identified the facility as "having a PSM plus additional patient safety staff." Based on the survey results, 36 out of 39 complexity level 1a facilities (see below for definition) had a PSM response to the survey and based on the survey responses, all 36 facilities were identified as "having a PSM plus additional patient safety staff."

[33] *VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance*. The PSM is responsible for reviewing JPSR events; determining whether further action, such as an RCA is required; reviewing actions for completeness; and closing the JPSR event.

Effect of Staffing on Fulfilling Patient Safety Program Requirements

Once aware of any patient safety event, facility staff must inform a PSM of the event for further review and should utilize the JPSR system to report a patient safety event.[34] VHA guidance establishes that PSMs are responsible for reviewing and following up on each JPSR event and ensuring the accuracy of the event within the JPSR system.[35] After review and follow-up of each JPSR event, PSMs must close events within 14 days of the reported date or the JPSR system will automatically mark the event overdue.[36]

The OIG reviewed overdue JPSR events for fiscal year 2021, compared by facility patient safety program staffing and facility complexity level.[37] The OIG found that on average, high and medium complexity level facilities (1b, 1c, and 2) with a PSM plus additional staff had a lower percentage of overdue JPSR events than facilities of the same complexity level with only one PSM.[38]

In addition, the OIG found that facilities that have a PSM and additional staff achieved a higher level of compliance with completing a minimum of eight patient safety analyses annually.[39] In fiscal year 2021, 44 percent (43) of facilities with a PSM plus additional patient safety program staff did not meet the annual requirement, as compared to 59 percent (20) of facilities with one PSM and no additional patient safety program staff.

Multiple variables including facility complexity, JPSR event volume, and facility patient safety program staffing impact the ability to meet VHA Patient Safety Program requirements and expectations. All factors must be considered in structuring a patient safety program staffing model.

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[34] VHA Handbook 1050.01; VHA Directive 1050.01. The directive references reporting adverse events as a VHA Patient Safety Program foundational principle as compared to the handbook, which requires facility staff to report adverse events; *VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance*.

[35] VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance.

[36] VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance.

[37] VHA Office of Productivity, Efficiency, and Staffing, "Facility Complexity Model Fact Sheet," accessed July 27, 2021. The Facility Complexity Model rates VHA facilities at levels 1a, 1b, 1c, 2, or 3, with "1a being the most complex and those rated 3 the least complex." Level 1a, 1b, and 1c facilities are considered high complexity, level 2 facilities are considered medium complexity, and level 3 facilities are considered low complexity. High complexity facilities have higher patient volumes, more complex clinical services, and larger teaching and research programs. Medium complexity facilities have "medium volume, low risk patients, few complex clinical programs and small or no research and teaching programs." Low complexity facilities have "low volume, low risk patients, few or no complex clinical programs and small or no research and teaching programs."

[38] Complexity level 1a facilities were not included in this comparison as all 1a facilities have a PSM and additional staff.

[39] VHA Handbook 1050.01; VHA Directive 1050.01. VHA Deputy Under Secretary for Health for Organizational Excellence, "Annual Minimum Requirements for Facilities to Perform Patient Safety Analyses," memorandum. VHA Assistant Under Secretary for Health for Quality and Patient Safety, "Annual Minimum requirements for Facilities to Perform Patient Safety Analyses."

VISN Patient Safety Program Staffing

The OIG surveyed PSOs to assess current staffing within the VISN patient safety programs. Fourteen PSO respondents indicated they were assigned as the PSO full-time, and two respondents indicated they dedicated 50–75 percent of their time to responsibilities of the VISN patient safety program each week. Only two PSOs identified having additional support staff, leaving most PSOs with no additional support staff for the VISN patient safety programs. Twelve PSOs reported having oversight responsibilities for programs in addition to the VISN patient safety program. Other program responsibilities included the following:

- electronic health record (EHR) modernization
- high reliability organization
- infection prevention and control
- risk management
- safe patient handling and mobility
- state veterans home
- sterile processing

The OIG found that 57 percent of PSMs (105) and 33 percent of PSOs (6) reported feelings of burnout in their roles. These high percentages suggest that burnout is an important issue within the patient safety program and that VHA must take further actions to address possible causes.

Patient Safety Officer and Patient Safety Manager Training

To be successful, healthcare systems depend on the performance of each individual employee within the organization. By providing adequate training to employees, healthcare systems help develop the skills, knowledge, and abilities that both motivate employees and result in higher employee performance. PSMs and PSOs require specialized skills and knowledge of VHA and facility structure and processes. Although VHA recommends training for PSMs and other staff involved in patient safety activities, there are no formalized or standardized training requirements for PSMs and PSOs.[40]

No PSM or PSO survey respondents reported receiving no training for their position.[41] However, only 44 percent (81) of PSMs and 56 percent (10) of PSOs affirmed that the training they received adequately prepared them for their positions.

During interviews, PSOs described a steep learning curve for new PSMs and identified the need to develop necessary skills, including learning the JPSR system and patient safety alert computer

[40] VHA Handbook 1050.01; VHA Directive 1050.01. Neither of the two policies specify requirements related to PSM and PSO patient safety training.

[41] Respondents were provided the option to select *no training*.

software, adapting to a systems approach way of thinking, and effectively building relationships with leaders across organizational lines.

NCPS stopped providing Patient Safety Improvement 101 and Patient Safety 201 training in 2019 with no alternative training in place, leaving PSOs with the responsibility of training new and current PSMs.[42] When the OIG asked PSOs to identify who is currently responsible for providing PSM training, four PSOs indicated a shared responsibility between the facility and the PSO, nine PSOs stated that training was the responsibility of the PSO, two PSOs indicated the responsibility was shared between the PSO and NCPS, two PSOs indicated that NCPS is responsible and one PSO indicated the responsibility was unclear. PSOs also reported that in the absence of NCPS patient safety training, they developed and provided training through the Patient Safety Program Academy. One PSO reported that PSOs provided Patient Safety Program Academy training virtually over the course of six to eight weeks that included a 42-hour curriculum on various patient safety topics.

During interviews, the NCPS Executive Director reported that, although Patient Safety Improvement 101 and Patient Safety 201 training was currently on hold, in fiscal year 2023, NCPS will provide the Patient Safety Program Academy training.[43]

The OIG concluded that there are opportunities to improve job training for PSMs and PSOs to include standardized, initial, and continuing formal training. Patient safety is an important healthcare topic that requires specialized training for patient safety professionals tasked with leading facility and VISN patient safety programs.

The OIG made one recommendation to the VHA Under Secretary for Health related to evaluating PSO and PSM communication with community care third-party administrators and two recommendations to the Assistant Under Secretary for Health for Quality and Safety related to establishing requirements for patient safety oversight of facility patient safety programs and evaluating barriers that limit engagement between VISN and facility directors and PSOs and PSMs.

The OIG made six recommendations to the NCPS Executive Director related to evaluating quarterly reports, PSO and PSM burnout and training, developing a patient safety program staffing configuration for PSMs and staffing guidance for VISN patient safety programs, and

[42] Patient Safety Improvement 101 and Patient Safety 201 are NCPS training programs. Patient Safety Improvement 101 is inclusive of patient safety concepts, processes, and policies designed for patient safety and quality improvement professionals. Patient Safety 201 provides tools, techniques, and skills to develop patient safety leaders. NCPS staff confirmed with the OIG that NCPS provided the final Patient Safety Improvement 101 training in September 2019 and final Patient Safety 201 training in March 2019. In an interview, the NCPS Executive Director told the OIG that the previous NCPS Executive Director made the decision to halt patient safety education, and instead chose to focus NCPS efforts on research, publication, and policy.

[43] The OIG received confirmation from an NCPS staff member that starting in January 2023, NPCS began providing Patient Safety Program Academy training.

implementing formalized training for newly appointed PSMs and PSOs and ongoing training for all PSOs and PSMs.

VA Comments

The Under Secretary for Health, Assistant Under Secretary for Health for Quality and Patient Safety, and Executive Director, National Center for Patient Safety concurred with the recommendations and provided acceptable action plans (see appendixes D, E, and F). The OIG will follow up on the planned actions until they are completed.

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Contents

Abbreviations

EHR	Electronic Health Record
FY	fiscal year
JPSR	Joint Patient Safety Reporting
NCPS	National Center for Patient Safety
OIG	Office of Inspector General
PSM	patient safety manager
PSO	patient safety officer
RCA	root cause analysis
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a review of Veterans Health Administration's (VHA) Patient Safety Program to assess oversight, culture of safety, staffing, and training. This report stems from OIG's concerns regarding the ability of VHA to promote and support patient safety initiatives with current processes and program structure. A lack of VHA oversight of factors affecting patient safety has been a recurring theme in recent OIG report publications (see appendix A).[1]

Background

Patient safety, as defined by the World Health Organization, "is the prevention of errors and adverse effects to patients associated with health care."[2] "Establishing cultures, processes, procedures, behaviors, technologies, and environments in health care" that focus on patient safety "lowers risks of patient harm and reduces the incidence of errors."[3]

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VHA established National Center for Patient Safety (NCPS) in 1999 "to lead VA's patient safety efforts" with the primary goal of reducing and preventing patient harm resulting from medical

[1] The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together; During the three-year period of July 1, 2019, through June 30, 2022, 23 percent (31 of 135) of OIG published hotline healthcare inspection reports and 22 percent (29 of 134) of comprehensive healthcare inspection reports had at least one recommendation related to VHA's Patient Safety Program.

[2] "Patient Safety," World Health Organization, accessed January 31, 2023, https://www.who.int/europe/health-topics/patient-safety#tab=tab_1.

[3] "Patient Safety," World Health Organization, accessed January 3, 2023, https://www.who.int/europe/health-topics/patient-safety#tab=tab_1.

[4] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. The handbook was in effect at the time of the review until it was rescinded and replaced by VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. Unless otherwise specified, the two policies contain similar language related to VHA's Patient Safety Program.

[5] VHA Directive 1050.01. For the purposes of this report, "VHA Patient Safety Program" refers to the VHA, VISN, and facility patient safety programs. VA administers healthcare services through a nationwide network of 18 regional systems referred to as Veterans Integrated Service Networks.

care.[6] NCPS is within the VHA Office of the Assistant Under Secretary for Health for Quality and Patient Safety. Significantly, NCPS does not have any independent authority over VISNs or facilities.

Key leaders who support patient safety efforts include VISN patient safety officers (PSO) who are accountable to VISN network directors. VISN PSOs do not have any specific authority over facility patient safety programs.[7] VHA policy establishes that facility patient safety programs, managed and overseen by patient safety managers (PSM), are aligned under facility directors (see figure 1).[8]

[6] "About Us," VA, National Center for Patient Safety, accessed October 20, 2022, https://dvagov.sharepoint.com/sites/vhancps/SitePages/About-us.aspx. (This site is not publicly accessible.)

[7] VHA Directive 1050.01. PSO responsibilities include "serving as the principal advisor for each VA medical facility in the VISN and facility leadership."

[8] VHA Handbook 1050.01. Based on review of VHA Handbook 1050.01, the OIG found no written policy for the facility patient safety program to be in alignment under the facility director; however, VHA Directive 1050.01 references the alignment of the patient safety program under the facility director.

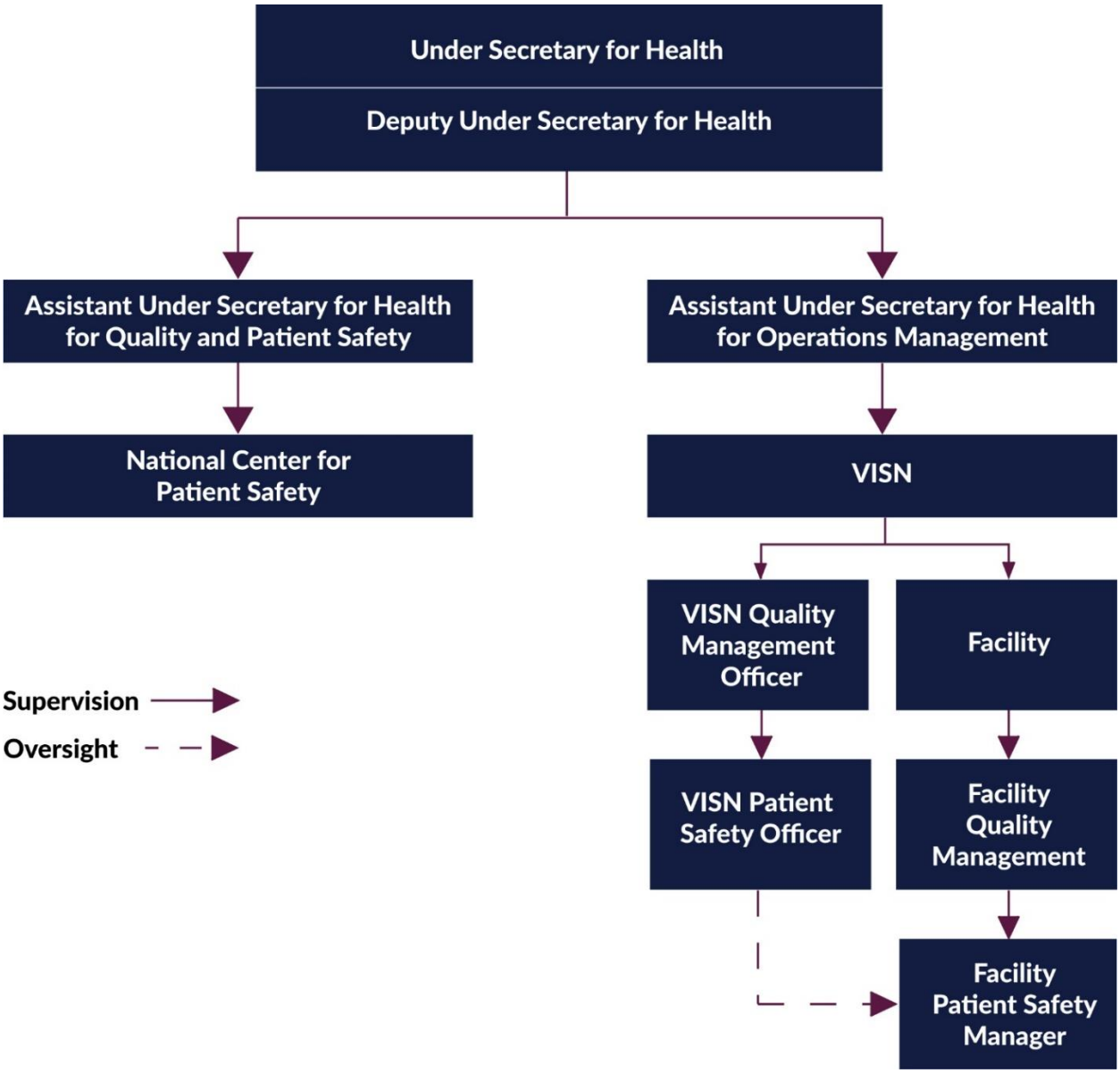

Figure 1. *VHA Patient Safety Program organizational structure.*
Source: VHA Organization Chart (dated July 1, 2020), PSO Interviews, and PSO and PSM surveys.
Note: The organization chart reflects the reporting structure of NCPS, PSOs, and PSMs and how most PSOs and PSMs are aligned based on PSO interviews and PSO and PSM surveys.

VISN and Facility Patient Safety Staff

VISN Patient Safety Officers

Per VHA, PSO duties include oversight and implementation of VHA's Patient Safety Program including the following:

- Ensure national program goals are met.
- Trend and analyze patient safety reports across the network.

- Provide program support to PSMs.
- Monitor the quality and progress of patient safety analyses and actions at facilities in the VISN.
- Complete reviews of each facility patient safety program in the VISN and communicating opportunities for improvement for the program to facility leaders and NCPS.[9]

Facility Patient Safety Managers

PSMs are responsible for various duties with the framework of VHA's Patient Safety Program including the following:

- Determine the response and actions following the reporting of unsafe conditions, adverse events, and close calls.
- Provide appropriate and timely feedback to known reporter(s) of events.
- Manage completion of patient safety alert actions and patient safety advisory recommendations.[10]

PSM responsibilities include promoting a culture of safety, providing training to facility staff, leading safety initiatives, improving healthcare environments, evaluating and revising policies to comply with regulatory standards, acting as an expert consultant, collaborating with internal and external customers, and sustaining safety improvements among several other duties.[11] A PSM may have additional responsibilities assigned such as multiple meeting attendance or integration with or oversight of other programs such as infection prevention and control or risk management.

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[9] "VHA VISN XX Network Functional Statement Patient Safety Officer Nurse IV," NCPS SharePoint, accessed June 22, 2022, https://dvagov.sharepoint.com/sites/vhancps/Shared%20Documents/Forms/Internal.aspx?id=%2Fsites%2Fvhancps%2FShared%20Documents%2FPatient%20Safety%20Professionals%20Position%20and%20Mentoring%20Resources%2FFunctional%20Statements%2FPatient%20Safety%20Officer%2FExample%20VHA%20Patient%20Safety%20Officer%5FFS%5FNurse%20IV%2Epdf&parent=%2Fsites%2Fvhancps%2FShared%20Documents%2FPatient%20Safety%20Professionals%20Position%20and%20Mentoring%20Resources%2FFunctional%20Statements%2FPatient%20Safety%20Officer. (This site is not publicly accessible.) An example nurse IV functional statement obtained from NCPS provided the scope of responsibility, qualifications, and assigned duties; *VHA National Center for Patient Safety Guidebook for Completing Facility Patient Safety Program Reviews*, October 2021. The guidebook states that the patient safety program review is an assessment of the quality of a facility patient safety program; VHA Directive 1050.01. PSO responsibilities include "serving as the principal advisor for each VA medical facility in the VISN and facility leadership."

[10] VHA Handbook 1050.01; VHA Directive 1050.01. The directive includes additional PSM responsibilities as compared to the handbook. The PSM has responsibility for implementing and monitoring patient safety improvements related to facilities' required patient safety analyses.

[11] PSM responsibilities were identified in a sample description of duties available on the center's SharePoint site. "Policy, Resources & Publications," National Center for Patient Safety, https://dvagov.sharepoint.com/sites/vhancps/SitePages/Resources.aspx?cid=c1d06ecb-5286-48b2-a5e7-8436c706ca91. (This site is not publicly accessible.)

NCPS Environmental Scans

The OIG learned that NCPS requested the VHA Office of Product Effectiveness conduct an environmental scan as an internal look at the current status of VHA's Patient Safety Program and identify best practices and patient safety trends within the healthcare industry.[12] A baseline assessment report *National Center for Patient Safety (NCPS) Patient Safety Environmental Scan Final Report* (Environmental Scan Phase I), was published on November 12, 2021, and a second report *National Center for Patient Safety (NCPS) Patient Safety Environmental Scan Phase II, Initiative I* (Environmental Scan Phase II), was published on June 8, 2022.[13] The methodology for the Environmental Scan Phase I included a literature search, review of VHA data, and interviews with staff at NCPS, VISNs, and facilities. Environmental Scan Phase II methodology incorporated findings from additional interviews with staff from VHA program offices, NCPS, VISNs, and facilities, including patient safety staff. Environmental Scan Phase I results cited critical components needed by VHA to ensure an "effective, efficient, and sustainable" patient safety program, including communication and connection across systems, leadership engagement, ongoing learning, and standardized examination of patient safety events. Environmental Scan Phase II results identified opportunities where NCPS could better engage with and provide support to staff in the field, along with reinforcement of just culture principles.

Prior OIG Reports

Hotline Healthcare Inspections

For the period of July 1, 2019, through June 30, 2022, 23 percent (31 of 135) of OIG published hotline healthcare inspection reports had at least one recommendation related to VHA's Patient Safety Program (see appendix A).[14] Patient safety event reporting and root cause analysis (RCA) processes were the most common areas cited. The OIG made 51 recommendations, 100 percent (51) of which have been closed.

[12] Product effectiveness, within the VHA Office of Quality and Patient Safety, evaluates the "effectiveness, efficiency and value" of a healthcare product. "Product Effectiveness Services to VA/VHA," VHA Office of Quality and Patient Safety, accessed November 2, 2022, https://vaww.qps.med.va.gov/divisions/ncps/pe/peFAQs.aspx. The OIG obtained the 2021 and 2022 assessment reports from NCPS and reviewed them as part of this inspection. (This site is not publicly accessible.)

[13] The OIG obtained the National Center for Patient Safety Environmental Scan Phase I and National Center for Patient Safety Environmental Scan Phase II reports from the NCPS and reviewed them as part of this inspection.

[14] The OIG selected this time frame based on the date the inspection was initiated and included three years of inspection reports.

Electronic Health Record Modernization

In fiscal year (FY) 2022, the OIG published five healthcare inspection reports related to the electronic health record (EHR) modernization implementation process.[15] The reports focused on quality and patient safety risks, medication management, ticket processing, and care coordination.[16] The OIG found a number of potential patient safety issues such as work-arounds, inaccurate medication lists, and lack of access to suicide risk assessment prevention tools. The OIG made 10 recommendations related to EHR modernization. As of June 14, 2023, 8 of the 10 recommendations remained open.

Comprehensive Healthcare Inspection Program

For the period of July 1, 2019, through June 30, 2022, 22 percent (29 of 134) of OIG published comprehensive healthcare inspection reports had at least one recommendation related to VHA's Patient Safety Program (see appendix A). The OIG made 46 recommendations; 100 percent (46) of the recommendations have been closed.

VA OIG Congressional Testimonies

On October 27, 2021, the Deputy Assistant Inspector General of the Office of Healthcare Inspections provided testimony to the Subcommittee on Health for the US House of Representatives Committee on Veterans' Affairs.[17] The testimony highlighted patient safety events that resulted in significant veteran harm, including death. Additionally, on May 11, 2022, the Inspector General provided testimony to the US Senate Committee on Veterans' Affairs highlighting the quality and safety of VA's health care. Both testimonies highlighted VHA's

[15] The budget office of the US Government defines a fiscal year as October 1 of one calendar year through September 30 of the next. "Budget of the US Government," accessed November 28, 2022; VA OIG, *The New Electronic Health Record's Unknown Queue Caused Multiple Events of Patient Harm*, Report No. 22-01137-204, July 14, 2022; VA OIG, *Deficits with Metrics Following Implementation of the New Electronic Health Record at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-03020-168, June 1, 2022; VA OIG, *Ticket Process Concerns and Underlying Factors Contributing to Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00781-108, March 17, 2022; VA OIG, *Medication Management Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00656-110, March 17, 2022; VA OIG, *Care Coordination Deficiencies after the New Electronic Health Record Go-Live at the Mann-Grandstaff VA Medical Center in Spokane, Washington*, Report No. 21-00781-109, March 17, 2022. The five electronic health record modernization reports were not included in the 135 hotline inspection reports referenced in this section.

[16] During implementation of the new EHR, facility staff entered tickets to request assistance or report issues. The ticket system was used to document the issue and any actions that were taken.

[17] *Hearing on Lessons Learned? Building a Culture of Patient Safety Within the Veterans Health Administration*, Before the Subcommittee on Health, 117th Cong. (October 27, 2021) (statement of Julie Kroviak, MD, Deputy Assistant Inspector General, VA Office of Inspector General).

need to improve the culture of safety.[18] On February 28, 2023, the Inspector General provided testimony to the US House of Representatives Committee on Veterans' Affairs highlighting how weaknesses in VA accountability negatively affected veterans, their families, and caregivers. The Inspector General stressed the need for VA to focus more on key elements of accountability, including the importance of clear roles and responsibilities, the need for adequate and qualified staff to perform duties, and effective oversight through quality assurance and monitoring.[19]

Scope and Methodology

The OIG conducted a national survey of PSMs (PSM survey) and a separate survey of PSOs (PSO survey) and interviewed the Assistant Undersecretary for Health for Quality and Patient Safety, the NCPS Executive Director, and 18 PSOs.[20] The OIG also reviewed relevant VHA policies; guidelines; and other administrative reports related to patient safety, PSMs, PSOs, and NCPS.

Survey Development and Distribution

The OIG developed the PSM and PSO surveys to gain insight about the experiences of PSMs and PSOs. The PSM survey consisted of 49 multiple choice, numerical entry, Likert scale, and narrative response questions. Respondents were provided additional questions based on responses to the 49 questions to provide additional information and clarification. The PSO survey consisted of 14 multiple choice, numerical entry, and Likert scale questions. Respondents were provided additional questions based on responses to the 14 questions to provide additional information and clarification. Both surveys focused on similar patient safety topics reported in previous OIG or NCPS reports including oversight, culture, staffing, and training (see figure 2).

[18] *Hearing on Quality of VA's Health Care, Before the Senate Committee on Veterans' Affairs*, 117th Cong. (May 11, 2022) (statement of Michael J. Missal, Inspector General, VA Office of Inspector General).

[19] *Hearing on Building an Accountable VA: Applying Lessons Learned to Drive Future Success*, Before the House Committee on Veterans' Affairs, 118th Cong. (February 28, 2023) (statement of Michael J. Missal, Inspector General, VA Office of Inspector General).

[20] The OIG determined the PSM survey response rate was representative of the PSM experiences and did not conduct PSM interviews.

Figure 2. *Patient safety manager and patient safety officer survey topics.*
Source: OIG patient safety officer and patient safety manager surveys.

The OIG distributed 217 PSM surveys and 18 PSO surveys on July 18, 2022, with a requested completion date of July 29, 2022.[21] Six of the 217 PSM surveys were excluded due to one duplicate survey and five surveys sent to individuals who were no longer in the role of PSM. Of the total surveys received (211), 87 percent of PSMs (184) and 89 percent of PSOs (16) responded (see appendix B).[22]

Survey Analysis

The OIG analyzed survey responses by calculating the frequency of closed-ended responses to questions to determine respondents' perspectives on select aspects of the PSM and PSO roles, experiences, and duties. The OIG also reviewed survey open-ended responses associated with select questions to identify themes and further understand respondents' perspectives and

[21] In response to a request by the OIG, PSOs provided the names of PSMs at each facility in their VISN. The OIG sent surveys to all PSMs identified by PSOs.

[22] The OIG did not receive completed survey responses from 27 facility PSMs and two VISN PSOs. The OIG utilized the survey as the sole data source for PSMs and analyzed the completed responses from 184 PSMs at 132 facilities. Survey data and interview data were obtained from PSOs of 18 VISNs. The OIG reported the results for all 18 PSOs interviewed, and when applicable, noted the non-respondents in survey results. The OIG did not grant extensions (see appendix B for additional details).

explanations. The OIG did not assess the survey responses from the respondents for accuracy or completeness.

Interviews

The OIG conducted virtual interviews with 18 PSOs to assess responsibilities, staffing, training, oversight of facility patient safety program requirements, and opportunities for improvement. The OIG also conducted virtual interviews with the Assistant Undersecretary for Health for Quality and Patient Safety and the NCPS Executive Director to understand the mission, vision, and goals of VHA's Patient Safety Program.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–24. 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 review in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Review Results

Based on the analysis of the survey results and interview information, the OIG found variabilities in NCPS and VISN oversight of facility patient safety programs and facility patient safety program staffing. Additionally, VISN and facility staff identified barriers to fostering a strong safety culture and providing standardized patient safety training.

1. Oversight of VHA Patient Safety Programs

NCPS Responsibilities

NCPS provides direction and guidance to VHA about policies and strategies to "measure and mitigate harm to the [patient] and those who support their care."[23]

[23] "Quality and Patient Safety," VHA Office of Quality and Patient Safety, accessed July 5, 2022, https://vaww.qps.med.va.gov/default.aspx. (This site is not publicly accessible.)

VHA's Office of the Under Secretary for Health publishes the VHA National Patient Safety Improvement Handbook and annual requirement memoranda, which outline facility requirements to achieve VHA's Patient Safety Program goal of preventing harm to patients.[24]

These requirements consist of the identification of patient safety events, patient safety event reporting, and completion of a minimum of eight patient safety analyses annually, including the following:

- root cause analysis (RCA)
- proactive risk assessments
- patient safety assessment tool evaluations

During interviews with the OIG, when asked about NCPS's role when facilities do not meet patient safety program requirements or have other program deficiencies, the Assistant Under Secretary for Health for Quality and Patient Safety indicated that when a facility patient safety program "isn't as strong as it should be. . . we'll intervene from the national level but will involve the VISN and will rely mostly upon the VISN to execute whatever intervention is necessary with. . . our support from the top." When asked if the role of NCPS was to be consultative, provide oversight or both, the NCPS Executive Director responded "we [NCPS] hold people to standards" and "are here to set a standard."

NCPS Quarterly Reports

NCPS develops quarterly reports which contain facility patient safety analyses data collected from the Joint Patient Safety Reporting (JPSR) system, SPOT, and other VHA data sources.[25] Quarterly reports also include VISN and national level comparisons of patient safety event data and completion of patient safety analyses requirements.[26] According to NCPS, quarterly reports are "intended to promote safety, quality, standardization, increased event reporting and high

[24] VHA Handbook 1050.01; VHA Directive 1050.01; VHA Deputy Under Secretary for Health for Organizational Excellence, "Annual Minimum Requirements for Facilities to Perform Patient Safety Analyses," memorandum to VISN Directors (10N1–23), March 17, 2020; VHA Assistant Under Secretary for Health for Quality and Patient Safety, "Annual Minimum Requirements for Facilities to Perform Patient Safety Analyses," memorandum to VISN Directors (10N1–23), April 25, 2022. The 2020 and 2022 memoranda provided clarification on the annual requirement for patient safety analyses. VHA Directive 1050.01 rescinded the 2022 memorandum but maintained the annual analyses requirement. The directive also describes reporting adverse events as a VHA Patient Safety Program foundational principle and outlines a requirement for reporting patient safety events.

[25] "VHA NCPS Patient Safety Quarterly Report Interpretation Document, Fiscal Year 2022 Quarter 2," September 8, 2022; VHA Handbook 1050.01; VHA Directive 1050.01; VHA Deputy Under Secretary for Health for Organizational Excellence, "Annual Minimum Requirements for Facilities to Perform Patient Safety Analyses," memorandum; VHA Assistant Under Secretary for Health for Quality and Patient Safety, "Annual Minimum Requirements for Facilities to Perform Patient Safety Analyses," memorandum.

[26] An NCPS staff member told the OIG that the NCPS notifies PSOs and PSMs by email when the quarterly reports are available for review on a secure website. PSOs and PSMs can download the report and share with facility and VISN staff.

reliability."[27] The NCPS Executive Director told the OIG that the intent of the quarterly reports was "to drive improvement and drive awareness of patient safety."

In response to the PSM survey, 84 percent (154) of PSMs indicated they receive the quarterly reports, 7 percent (12) of PSMs indicated they receive the quarterly reports sometimes, while 10 percent (18) of PSMs indicated they do not receive the quarterly reports.

When asked "How do you use the report in your job?" 9 percent (14 of 154) of PSMs who reported receiving quarterly reports answered, "report not used." When asked to further explain why quarterly reports are not utilized, PSMs indicated the following in the survey responses:

- Quarterly reports are not received timely.
- Quarterly reports are too lengthy.
- Quarterly report data was accessible from the JPSR system.
- Some quarterly report data is outside of the scope of the facility patient safety program.
- There is a lack of understanding on how to interpret the data.
- The reports are not meaningful or useful.

During interviews with the OIG, the Assistant Undersecretary for Health for Quality and Patient Safety reported streamlining the quarterly reports to make the quarterly reports more useful to staff who receive the reports. The VHA's Assistant Secretary for Health for Quality and Patient Safety acknowledged that the quarterly reports have been a "work in progress," initially sent to PSMs with little guidance and there was a recent focus on making the reports more useful to staff by including an explanation about the data analysis and expectations on use of the data. The NCPS Executive Director explained changes were made to the reports, which included making reports shorter, providing the reports more timely, adding visualizations and charts, and explaining report data.[28] When asked what patient safety program improvements were needed, two PSOs identified having a national analysis of facility patient safety data and finding opportunities to make meaningful changes based on patient safety data analyses. One PSO reported,

> [I would] really like to see something more succinct with those quarterly reports, more succinct analysis of what's going on with JPSR or with the [patient safety assessment tools] … We're getting data…, but we're not getting the analysis of what that data really means.

[27] "VHA NCPS Patient Safety Quarterly Report Interpretation Document, Fiscal Year 2022 Quarter 2."

[28] In October 2022, an NCPS staff member provided a second quarter fiscal year NCPS report to the OIG. The OIG noted additional visualizations and charts in the report as compared to fiscal year 2021 quarterly reports. The same staff member provided, "VHA NCPS Patient Safety Quarterly Report Interpretation Document, Fiscal Year 2022," which included report data explanations.

Another PSO stated,

> We need data analysts to help us look at [patient safety] data in meaningful ways beyond just some bar graphs that we can pull out of a JPSR report, so we need more analyst support to analyze this data, to proactively [identify] themes to help us reduce harm.

The OIG determined that while the quarterly reports included patient safety program data such as volume of JPSR events reported and patient safety analyses completed, they did not provide a qualitative analysis of patient safety data. For example, the quarterly reports referenced the number of adverse events but did not include an analysis of actions initiated in response to adverse events.[29] The OIG concluded that while the intent of the quarterly reports was to drive patient safety improvements, how to make improvements or change was not identified in the quarterly reports. The OIG agrees that a shift to include an analysis of patient safety data in the quarterly reports would be helpful to staff. A focus on using data to drive process changes can lower or have potential to lower risk of patient harm.

VISN Patient Safety Officer Oversight

To understand the role of PSOs in providing oversight to facility patient safety programs, the OIG assessed VISN oversight of facility patient safety programs through the review of VHA guidance and PSO survey responses and interviews.

The *National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance* states that PSOs are responsible for overseeing that facilities monitor and investigate JPSR events and that PSOs "will review a subset of all [JPSR] event reports," but does not define the frequency or volume of the reviews required.[30]

Of the 16 PSOs who responded to the survey

- All PSOs reported conducting site visits to evaluate patient safety programs at each facility in their VISN.
    - Thirteen conducted visits annually.
    - One conducted visits every two years.
    - One conducted virtual visits quarterly and on-site visits annually.

[29] During this review, the OIG evaluated a sample of the NCPS quarterly reports from FY 2021.

[30] VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance, November 2021. The rules discussed in this report are also covered by the VHA National Center for Patient Safety JPSR Business Rules and Guidebook, July 2020, and VA National Center for Patient Safety Joint Patient Safety Reporting (JPSR) System Business Rules, May 1, 2018. The three versions contain similar language related to the basic role of the PSO with additional details added in the 2021 versions. Unless otherwise noted, the November 2021 version is referenced throughout this report.

  - One indicated "other" but did not provide an explanation.
- Fifteen PSOs indicated they conduct site visits for specific concerns as needed in addition to scheduled site visits. One PSO indicated "NA" but did not provide further explanation.
- All PSOs reported reviewing completed RCAs; however, the percentage of RCAs reviewed by the PSOs varied:
  - Less than 10 percent (1)
  - 10–20 percent (4)
  - 21–40 percent (3)
  - 41–70 percent (2)
  - 71–90 percent (3)
  - 91–100 percent (3)

During interviews with the 18 PSOs, the OIG asked if the role of a PSO was to be consultative, provide oversight, or both. Most (17) of the PSOs responded that their role was a combination of both with one PSO indicating their role was consultative only. PSOs reported examples of oversight activities included JPSR data reviews and annual site visits while sharing best practices, leading monthly PSM calls, providing training, and developing quantifiable outcome measures for RCAs were examples of consultative functions. PSOs had differing responses when asked to whom they communicated deficiencies they identified through their oversight activities. Responses included a phone call or email to the facility PSM or Facility Director, or communication with the VISN quality management officer or the VISN Network Director.

During interviews, the OIG found that although all PSOs reported having processes to provide oversight of the implementation and quality of facility patient safety programs within each VISN, there is variability in oversight practices, which include the frequency and volume of reviews required. The OIG would expect VHA leaders to define requirements for PSOs' oversight of facility patient safety programs to include expectations for follow-up when patient safety program deficiencies are identified.

Oversight of Community Care Patient Safety

VHA "provides health care to eligible veterans using a combination of VHA and non-VHA providers and facilities."[31] Congress enacted the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (MISSION Act) to provide health care

[31] Congressional Budget Office, The Veterans Community Care Program: Background and Early Effects, October 2021.

through non-VA providers.[32] Veterans can receive care in the community through a network of providers managed by third-party administrators.[33] VHA guidance indicates that PSOs communicate and coordinate with third-party administrators' quality and patient safety representatives and provide "input and guidance on RCA corrective outcomes if applicable."[34] Additionally, VHA encourages PSOs and PSMs to communicate with third-party administrators when adverse events involving care in the community occur to ensure an analysis is completed.[35] VHA guidance encourages third-party administrators to provide an investigative analysis for adverse events, but notes "[third-party administrators] are not contractually required to provide a summary of findings from their investigation."[36]

The OIG surveyed PSOs to determine whether they meet with third-party administrators' quality and patient safety representatives. Six PSOs responded *yes*, while 10 PSOs responded *no*. PSOs stated that barriers to meeting with third-party administrators included the following:

- inconvenient meeting times
- not being included in meeting invitations
- not having established meetings
- third-party administrators not agreeing to or declining to meet

During interviews, all PSOs indicated there are processes in place to report quality and safety concerns to third-party administrators. Some PSOs reported feedback from the third-party administrators is limited to whether the review of concerns is in progress or complete. A PSO stated the process is "uncomfortable. . . [because PSOs] have to make sure [third-party administrators are] following up on safety events. . . we can't see [third-party administrators'] RCA[s]. . . but we have to somehow have confidence that they are doing [RCAs]."

During an interview with the OIG, the Assistant Under Secretary for Health for Quality and Patient Safety stated that VHA's "ability to intervene and respond to serious patient safety concerns in the community is very, very limited." The Assistant Under Secretary for Health for Quality and Patient Safety described the lack of a standardized quality process, which is dependent on whether a patient safety event occurs within or outside the VA. The Office of Integrated Veterans Care has their own patient safety structure and reporting and RCA process

[32] VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, Pub. L. No. 115-182, 132 Stat. 1393 § 505 (2018).

[33] VHA, "Community Care Network (CCN) Fact Sheet," updated January 21, 2022.

[34] Veterans' Health Administration Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook, February 2022.

[35] Veterans' Health Administration Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook.

[36] Veterans' Health Administration Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook.

for community care patients.[37] "Frontline [PSM] has to serve two masters if it's care received outside of the VA they got to go through IVC [Integrated Veterans Care], if [the care is] received within the VA, they work with NCPS." Lastly, the Assistant Under Secretary for Health for Quality and Patient Safety identified during an interview, a goal to achieve one standard for patient safety applicable to patients receiving care from VA or through community care.

The OIG concluded that although VHA guidance directs PSOs to communicate with third-party administrators regarding adverse events involving care in the community, PSOs identified barriers to meeting this expectation.

2. Culture of Safety

The Joint Commission defines safety culture within a healthcare system as a reflection of all staff's "beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety."[38] In organizations with a strong safety culture there is a "commitment to safety" and to "do no harm."[39] In a culture of safety, facility staff equally share the responsibility to minimize harm to patients.[40] Leaders must work to support integral parts critical to the efforts to develop a culture of safety such as teamwork and the ability to openly discuss concerns.[41] The failure of healthcare system leaders to foster an adequate safety culture can contribute to adverse events.[42]

In an effort to further cultivate a culture of safety, VHA began a journey to implement high reliability organization principles in February 2019.[43] High reliability organizations strive to operate without serious failures or accidents in complex systems that are often fraught with hazards. Within high reliability organizations, three pillars are established as key: leadership commitment, safety culture, and continuous process improvement.[44] High reliability

[37] VHA Acting Under Secretary for Health, "Notification of Program Office Reorganization," memorandum to VHA Senior Leaders, September 23, 2021. VHA's Office of Integrated Veteran Care oversees the administration of community care programs.

[38] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, E-dition, July 1, 2022. "Patient Safety Systems (PS)."

[39] Comprehensive Accreditation Manual for Hospitals, E-dition. "Patient Safety Systems (PS)."

[40] Comprehensive Accreditation Manual for Hospitals, E-dition. "Patient Safety Systems (PS)."

[41] The Joint Commission, *Standards Manual*, LD.03.01.01, July 1, 2022. "Leaders create and maintain a culture of safety and quality throughout the hospital."

[42] The Joint Commission, "The Essential Role of Leadership in Developing a Safety Culture," *Sentinel Event Alert* 57, (March 1, 2017, revised June 18, 2021).

[43] VHA, "High Reliability Organization (HRO) Fact Sheet," September 2021.

[44] VHA, "High Reliability Organization (HRO) Fact Sheet."

organizations include environments where safety concerns are anticipated and responded to prior to catastrophic outcomes.[45]

Prioritization of Patient Safety

The OIG surveyed PSMs and PSOs to better understand their perceptions of how patient safety is prioritized within their organizations.[46] Of the 184 PSMs who responded to the survey, 76 percent (139) of PSMs *agreed* or *strongly agreed* when asked if patient safety is an organizational priority considered during decision-making processes (see figure 3).

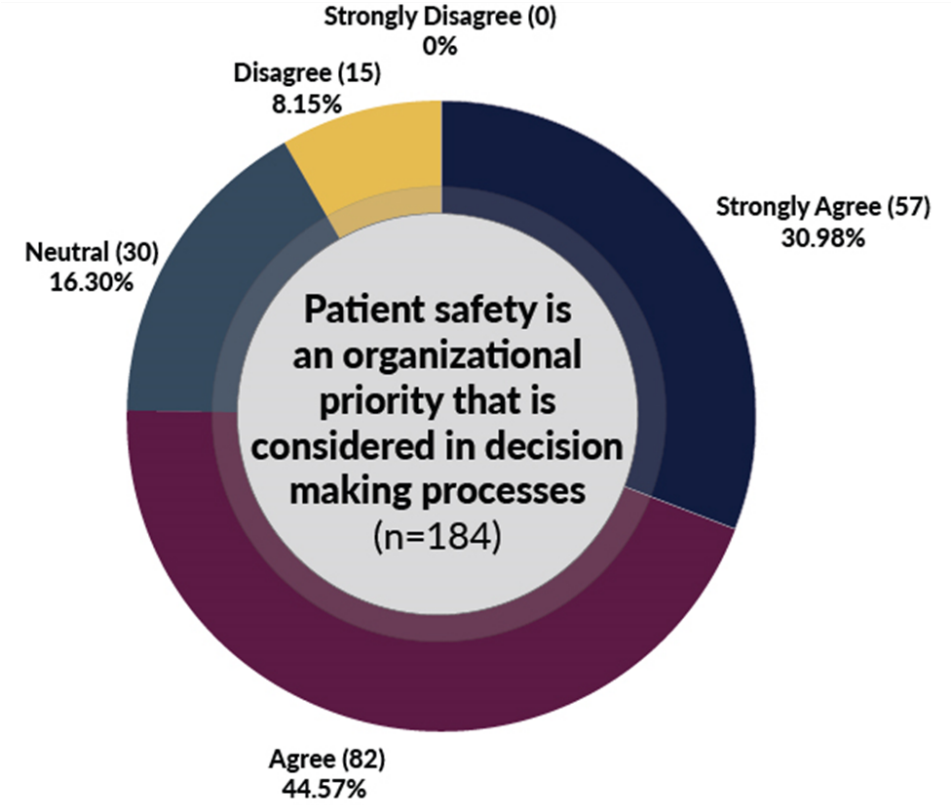

Figure 3. *Patient safety is an organizational priority.*
Source: OIG analysis of patient safety manager survey responses

Respondents who answered *disagree* (15) or *neutral* (30) were asked to provide an explanation, and some respondents described an environment where PSMs were sometimes left out of important organizational decisions.

[45] Agency for Healthcare Research and Quality, *PSNet: Patient Safety Network*, "High Reliability," September 7, 2019, https://psnet.ahrq.gov/primer/high-reliability.

[46] "Organization" refers to the facility or VISN.

PSOs were also asked to rate their agreement with the statement "Patient safety is a VISN priority that is considered in decision making processes." Twelve of the 16 PSOs who responded to the PSO survey either *agreed* or *strongly agreed* with the statement (see figure 4). Three of the 18 PSOs *disagreed* or strongly *disagreed* with the statement and provided a comment to explain their response. One of the three PSOs who commented indicated the VISN is interested in patient safety only when "[patient safety] becomes their concern," and VISN directors respond and react to what is on their performance plans and other identified priorities. A second PSO indicated that the VISN is only interested in patient safety if they have a concern over an event. The third PSO who commented, stated that "patient safety has never had a voice for any VISN decisions indicating in my opinion, the voice of patient safety is not a priority." The PSO described an exception with one decision when the PSO's input was requested but then immediately opposed and the PSO was "removed from the discussion."

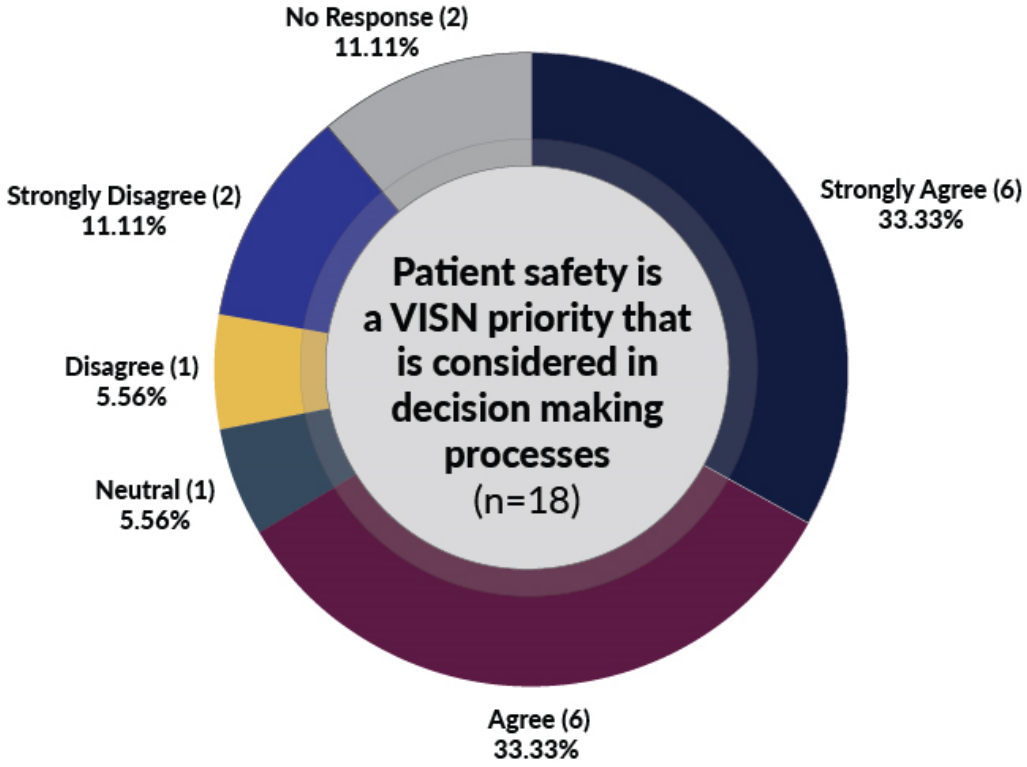

Figure 4. *Patient safety is a VISN priority that is considered in decision-making processes. Source: OIG analysis of patient safety officer survey responses.*

Executive Leadership Team Support

The OIG also surveyed PSMs to determine whether they felt supported by facility executive leadership teams when adverse events occurred.[47] Most PSMs (79 percent) (145) *agreed* or *strongly agreed* that facility executive leaders provided the necessary support (see figure 5).

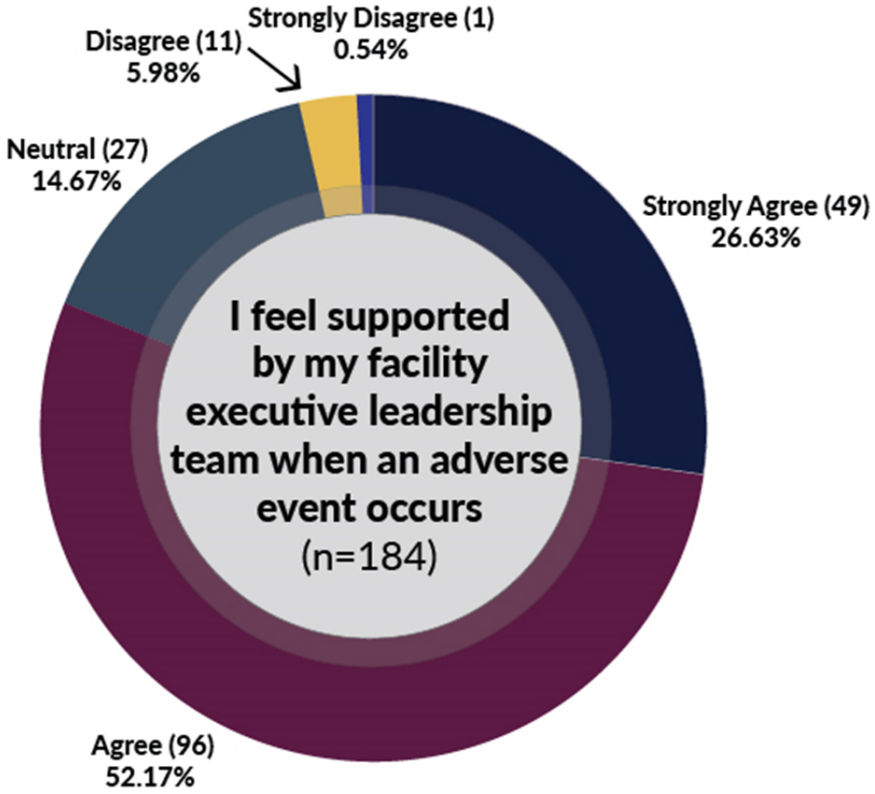

Figure 5. *Executive leadership team support*
Source: OIG analysis of patient safety manager survey responses

PSMs who did not agree were asked to provide further explanation. Some PSMs identified a lack of direct or limited contact with executive leaders describing "little personal interaction," "very difficult to get face time with executive leaders," and "I am not sure what is happening when something is escalated to executive leadership." Additional PSM comments included "[facility leadership are] not active listeners," and "verbal. . . support [given] when resources and removing barriers is what is needed." Other PSMs commented that they do not feel like part of a collaborative team, with adversarial relationships with leaders and staff, describing feelings as being perceived as, for example, "the enemy" or a "scapegoat."

[47] The OIG defined an executive leadership team as a facility director, chief of staff, associate director, and associate director for patient care services/nurse executive. The OIG recognizes that facilities may have variations of an executive leadership team.

PSMs also described a perception that facility leaders fail to hold staff accountable. One PSM responded "There is no authority in my role, so I depend on the confirmation of the necessity of actions. . . to come from leadership and it does not." Another PSM reported that actions "fall off [the] radar" of staff assigned with implementation of action plans and that when this occurs "the finger points back to Patient Safety as to why" staff failed to implement actions as assigned. A third PSM stated that "some leaders are giving [the] PSM pushbacks [*sic*] when actions are assigned to their areas." A fourth PSM noted "great support by the ELT [Executive Leadership Team] could improve responsiveness [of those assigned action items]."

The PSM survey inquired about the organizational reporting structure. Of PSMs surveyed, 77 percent (142) identified a similar structure, where the PSM reported directly to the facility quality manager. Eighty-seven percent (160) of PSMs reported having the opportunity to discuss patient safety concerns and RCAs with facility directors. In written comments, PSMs described a variety of interactions with facility directors, including weekly or monthly meetings and email communication.

Among 160 PSMs who had the opportunity to meet with the facility medical director 35 percent (56) answered *neutral*, *disagree*, or *strongly disagree*, when asked if the meetings with directors met the needs of the patient safety program. Respondents who provided additional comments on this question reported that interactions with facility directors must go through the facility quality manager and having to filter communication through the facility quality manager was a barrier to communication with facility directors. PSMs expressed the desire for more opportunities to have one-on-one meetings with facility directors to discuss program patient safety concerns, action items, and to receive feedback from facility directors on goals and expectations for patient safety.

The OIG concluded that most PSMs surveyed reported receiving support from facility executive leaders when an adverse event occurred. However, comments provided by PSMs identify limited communication which may inhibit their ability to build trusted relationships if left unaddressed by facility leaders. As VHA continues its high reliability organization journey and implementation of a culture of safety, the OIG would expect VISN and facility leaders to consistently place patient safety as a priority and engage PSMs and PSOs in discussions and decisions related to patient safety.

3. Patient Safety Program Staffing

Staffing can be defined as the "process of acquiring, deploying, and retaining a workforce of sufficient quantity and quality to create positive impacts on the organization's effectiveness."[48] The Joint Commission reports that insufficient staffing and excessive workload contributes to

[48] National Academies of Sciences, Engineering, and Medicine, "Models Applied to Staffing," chap. 3 in *Facilities Staffing Requirements for the Veterans Health Administration—Resource Planning and Methodology for the Future (2020)*, (Washington, DC: the National Academies Press, 2020), 30.

staff fatigue in the healthcare setting.[49] In addition, the COVID-19 pandemic has placed additional strain on a healthcare workforce already faced with existing shortages and "significant problems" with burnout and stress.[50] The OIG evaluated facility and VISN patient safety program staffing through the PSM and PSO survey responses and interviews, VHA policy, and documents received from NCPS. The OIG also evaluated the effect of facility patient safety program staffing and ability to meet VHA Patient Safety Program requirements.

Facility Patient Safety Program Staffing

VHA policy establishes that PSMs are responsible for several program duties within the framework of a facility patient safety program.[51] In addition, VHA policy designates the facility director to be responsible for ensuring completion of facility patient safety program requirements including the eight annual patient safety analyses.[52] However, at the time of the survey, based upon review of VHA Handbook 1050.01, the OIG found no written policy for the number of patient safety program staff required at facilities or that a PSM was a designated full-time equivalent position.[53]

The OIG surveyed PSMs to assess their education, background, time in their position, and the facility patient safety program staffing (see appendix C).

Based upon the survey results, PSM time in position varied from less than six months to greater than 10 years with more than half (54 percent) of PSMs having been in the position less than two years (see figure 6). In response to the survey, some PSMs identified a need for a standardized patient safety program staffing methodology that establishes the number of required patient safety staff based on facility complexity level.[54]

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[49] The Joint Commission, "Health Care Worker Fatigue and Patient Safety," *Sentinel Event Alert* 48, (December 14, 2011, addendum May 14, 2018).

[50] Assistant Secretary for Planning and Evaluation, Office of Health Policy, *Impact of the COVID-19 Pandemic on the Hospital and Outpatient Clinician Workforce*, HP-2022-13, May 3, 2022.

[51] VHA Handbook 1050.01; VHA Directive 1050.01. VHA Directive 1050.01 includes additional PSM responsibilities as compared to VHA Handbook 1050.01. The PSM has responsibility for implementing and monitoring patient safety improvements related to facilities' required patient safety analyses.

[52] VHA Handbook 1050.01; VHA Directive 1050.01.

[53] VHA Handbook 1050.01; VHA Directive 1050.01. The facility director is responsible for assigning a minimum of one full-time equivalent PSM position.

[54] VHA Office of Productivity, Efficiency, and Staffing. The Facility Complexity Model rates VHA facilities at levels 1a, 1b, 1c, 2, or 3 with "1a being the most complex and those rated 3 the least complex." Level 1a, 1b, and 1c facilities are considered high complexity, level 2 facilities are considered medium complexity, and level 3 facilities are considered low complexity. High complexity facilities have higher patient volumes, more complex clinical services, and larger teaching and research programs. Medium complexity facilities have "medium volume, low risk patients, few complex clinical programs and small or no research and teaching programs." Low complexity facilities have "low volume, low risk patients, few or no complex clinical programs and small or no research and teaching programs."

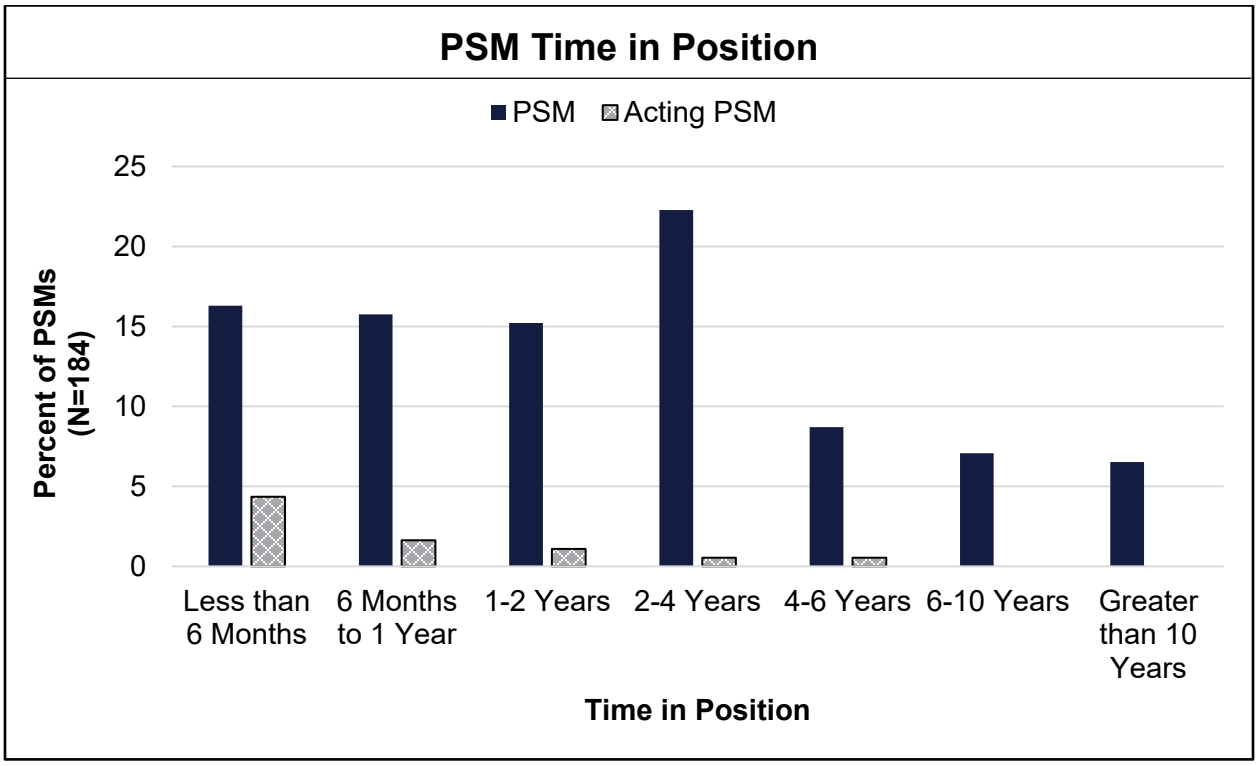

***Figure 6**. Patient safety manager time in position.*
Source: OIG analysis of patient safety manager survey responses

The OIG reviewed facility patient safety program staffing by facility complexity. The OIG found that all facilities with responses were staffed with at least one PSM and some facilities had additional staff assigned to patient safety.[55] Among the facilities with PSM respondents, the OIG found the following percent of facilities had one PSM plus additional patient safety staff assigned:

- 100 (36) percent complexity level 1a facilities
- 90 percent (19) complexity level 1b facilities
- 57 percent (12) complexity level 1c facilities
- 64 percent (14) of complexity level 2 facilities

[55] The OIG surveyed 211 PSMs in 138 out of 139 official facilities. The Joseph Maxwell Cleland Atlanta VA Medical Center PSM position was reported as vacant during the survey period and was not included in the survey. The OIG obtained survey responses from 184 PSMs in 132 facilities. The OIG used the survey responses to determine the status of additional patient safety staff other than a single PSM for each facility. If the facility had more than one PSM or the surveyed PSM indicated that there were additional staff assigned to patient safety program, the OIG identified the facility as "having a PSM plus additional patient safety staff." Based on the survey results, 36 out of 39 complexity level 1a facilities had a PSM response to the survey and based on the survey responses, all 36 these facilities were identified as "having a PSM plus additional patient safety staff."

- 52 percent (16) complexity level 3 facilities

During interviews with the OIG, when asked who determines facility patient safety program staffing, PSOs reported that while PSOs sometimes provided informal feedback or guidance regarding facility program staffing, ultimately facility leaders have the responsibility for determining staffing levels for facility patient safety programs. One PSO explained that in the absence of staffing guidance, the PSO makes staffing recommendations based on the volume of PSM workload, along with the number of PSMs needed to accomplish the program requirements. Another PSO explained that they have provided staffing guidance when consulted by facility leaders within their VISN but noted "It's hard because we don't have staffing standards."

Two PSOs described responses from facility leaders when discussing PSM staffing levels. One PSO reported, "I do have [facilities] that have been very short [of PSM staff] for a long time," and noted attempts at providing PSM staffing guidance to facilities were not "successful necessarily in being heard." Another PSO referred to guidance provided to facility leaders on patient safety program staffing as "consultive in nature," and reported the guidance was "not typically adhered to" by facility leaders.

The Environmental Scan Phase II identified challenges including PSM "heavy workload," "burnout," and "turnover."[56] The Environmental Scan Phase II also included a "significant concern" regarding PSMs having multiple responsibilities.[57]

Effect of Staffing on Fulfilling Patient Safety Program Requirements

The OIG evaluated the effect of staffing on the facilities' ability to meet patient safety program requirements, including management of JPSR events and patient safety analyses completion.

To become a highly reliable organization, staff at all levels within an organization must constantly assess systems for weaknesses and improvement opportunities and feel they can report identified patient safety events without fear of retribution.[58] VHA's goal of becoming a high reliability organization requires effective management of JPSR events by facility PSMs as

[56] VHA Office of Quality, Safety, and Value Optimizing Healthcare Value Program, "National Center for Patient Safety (NCPS) Patient Safety Environmental Scan Phase II, initiative I Final Report," June 8, 2022.

[57] VHA Office of Quality, Safety, and Value Optimizing Healthcare Value Program, "National Center for Patient Safety (NCPS) Patient Safety Environmental Scan Phase II, initiative I Final Report."

[58] Jennifer L. Sullivan, Peter E. Rivard, Marlena H. Shin, and Amy K. Rosen, "Applying the High Reliability Health Care Maturity Model to Assess Hospital Performance: A VA Case Study." The Joint Commission Journal on Quality and Patient Safety, Volume 42, no. 9 (September 2016): 389–399.

these reports provide the critical information needed to identify contributing causes and implement actions to prevent patient harm.[59]

Once aware of any patient safety event, VHA facility staff must inform a PSM of the event for further review and should utilize the JPSR system to report a patient safety event.[60] VHA guidance establishes that PSMs are responsible for the review and follow-up of each JPSR event and ensuring the accuracy of the event within the JPSR system.[61] After review and follow-up of each JPSR event, PSMs are responsible for assigning a safety assessment code to the event to determine whether further action, such as an RCA, is required.[62] PSMs may assign additional facility staff to investigate the patient safety event.[63] Once assigned an event for investigation, facility staff have seven days to complete a review of the event and enter required details into the JPSR system.[64] After investigation completion, a PSM reviews the JPSR event for completeness prior to finalizing and closing the event report.[65] PSMs must close JPSR events within 14 days of the reported date or the JPSR system will automatically mark the event overdue.[66]

Upon review of JPSR events reported by facility complexity level, the OIG found that higher complexity level facilities, on average, reported the largest number of JPSR events in 2021 (see

[59] VHA Handbook 1050.01, March 4, 2011; VHA Directive 1050.01, March 24, 2023. *VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance,* November 2021. The rules discussed in this report are also covered by the VHA National Center for Patient Safety JPSR Business Rules and Guidebook, July 2020, and *VA National Center for Patient Safety Joint Patient Safety Reporting (JPSR) System Business Rules*, May 1, 2018. The three versions contain similar language related to the basic role of the PSM with additional details added in the 2021 versions. Unless otherwise noted, the November 2021 version is the version referenced throughout this report.

[60] VHA Handbook 1050.01, March 4, 2011; VHA Directive 1050.01, March 24, 2023. VHA Directive 1050.01 March 24, 2023, references reporting adverse events as a VHA Patient Safety Program foundational principle as compared to VHA Handbook 1050.01, which requires facility staff to report adverse events; *VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance*.

[61] VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance.

[62] VHA Handbook 1050.01, March 4, 2011; VHA Directive 1050.01, March 24, 2023. The two policies contain similar language related to VHA's Patient Safety Program patient safety manager responsibilities for assigning a safety assessment code score to each reported JPSR event. A safety assessment code score ranges from one to three with three being the most severe; VHA, *National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance*.

[63] VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance.

[64] VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance.

[65] VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance.

[66] VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance.

table 1).[67] One PSM commented in the survey that the volume of JPSR events has significantly increased with the implementation of the EHR modernization.[68]

Table 1. JPSR Events by Facility Complexity Level

Complexity Level	Lowest Number of JPSR Events	Average Number of JPSR Events	Highest Number of JPSR Events
	FY 2021	*FY 2021*	*FY 2021*
1a High (N=39)	428	1658	2917
1b High (N=21)	286	1550	2349
1c High (N=23)	344	1054	1974
2 Medium (N=23)	187	879	3827
3 Low (N=32)	191	659	2119

Source: OIG analysis of facility patient safety program data.[69]

The OIG reviewed overdue JPSR events for FY 2021, compared by facility patient safety program staffing and facility complexity level (see figure 7). The OIG found that the average facility percentage of overdue JPSR events ranged from 12 to 37 percent among facilities with different complexity levels and PSM staffing status. High and medium complexity level facilities (1b, 1c, and 2) with a PSM plus additional staff had a lower average facility percentage of overdue JPSR events than facilities of the same complexity with only one PSM.[70] Complexity level 3 facilities with only one PSM had a lower average facility percentage of overdue JPSR events than facilities with a PSM plus additional staff. The OIG did not evaluate or complete further analysis to determine the reasons related to this data.

[67] The NCPS provided FY 2021 facility JPSR event data. The OIG did not independently verify VHA data for accuracy or completeness. The FY 2021 JPSR event report data provides the most recent complete data for a fiscal year within the time frame of this project review. The OIG chose to compare one year of JPSR events and patient safety program staffing.

[68] At the time of the survey (July 2022), five facilities had implemented EHR modernization.

[69] According to the VHA Office of Productivity, Efficiency & Staffing, the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois, is excluded from the complexity model. This facility is excluded from this table, all other 138 facilities are included.

[70] The comparison of overdue JPSR events by complexity and PSM staffing did not include 1a facilities because all 1a facilities have one PSM plus additional staff.

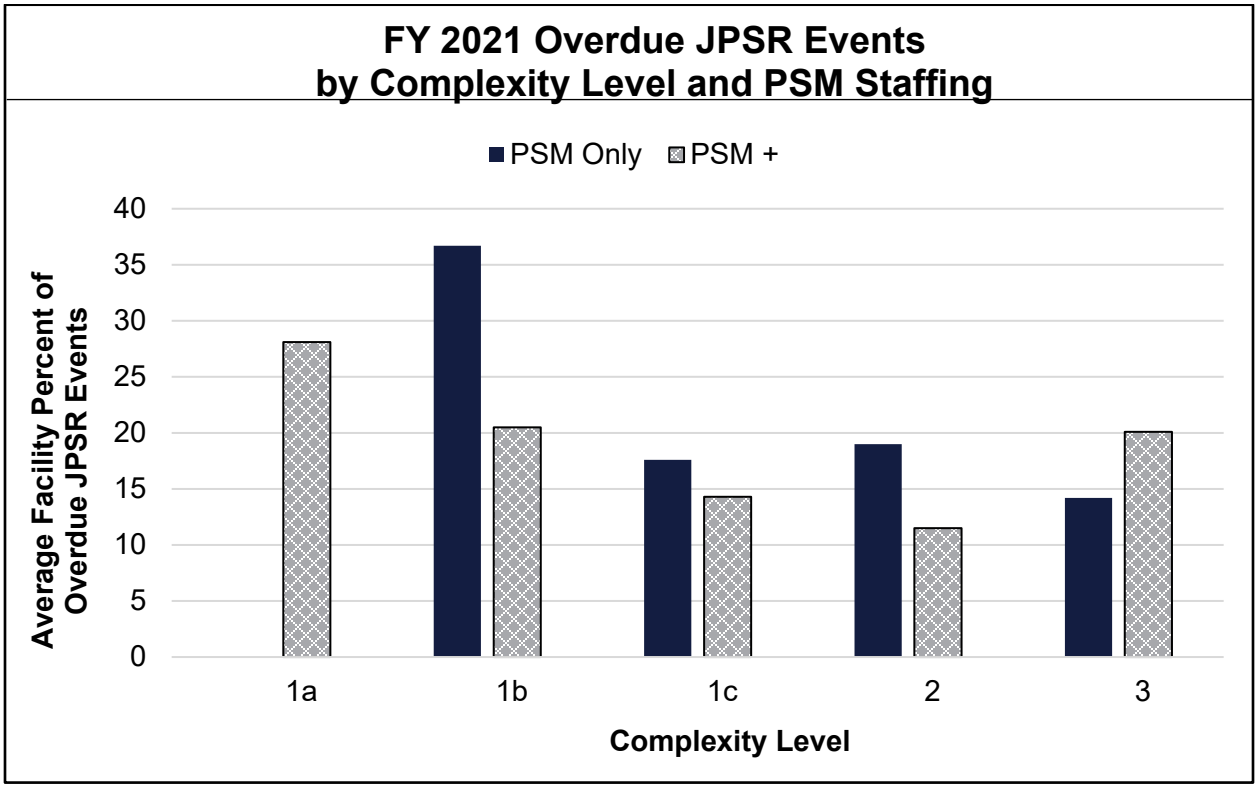

***Figure 7**. Average Facility Percentage of Overdue JPSR events by complexity level and PSM staffing.*
Source: OIG analysis of facility patient safety program data.[71]
Note: All complexity level 1a facilities have a PSM plus additional staff.

PSMs' ability to meet the established time frame for completion of JPSR events varied by facility complexity, JPSR event volume, and PSM staffing. However, the OIG found that most facilities were not able to meet the goal to complete JPSR events within 14 days in FY 2021.

The OIG reviewed facility compliance with meeting the patient safety analyses requirement and found that facilities that have a PSM and additional staff achieved a higher level of compliance with completing a minimum of eight patient safety analyses annually.[72] In FY 2021, 44 percent (43) of facilities with a PSM plus additional patient safety program staff did not meet the annual

[71] According to the VHA Office of Productivity, Efficiency & Staffing, the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois, is excluded from the complexity model. The analysis for this figure excluded this facility and seven facilities having no PSM respondents.

[72] VHA Handbook 1050.01, March 4, 2011; VHA Directive 1050.01, March 24, 2023. The two policies contain similar language related to a facility's patient safety program requirements; VHA Deputy Under Secretary for Health for Organizational Excellence memorandum, "Annual Minimum Requirements for Facilities to Perform Patient Safety Analyses," March 17, 2020; VHA Assistant Under Secretary for Health for Quality and Patient Safety memorandum, "Annual Minimum requirements for Facilities to Perform Patient Safety Analyses," April 25, 2022; VHA Directive 1050.01, March 24, 2023, rescinded the 2022 memorandum. Appendix A includes the annual requirements previously included in the memorandum.

requirement, as compared to 59 percent (20) of facilities with one PSM and no additional patient safety program staff (see figure 8).

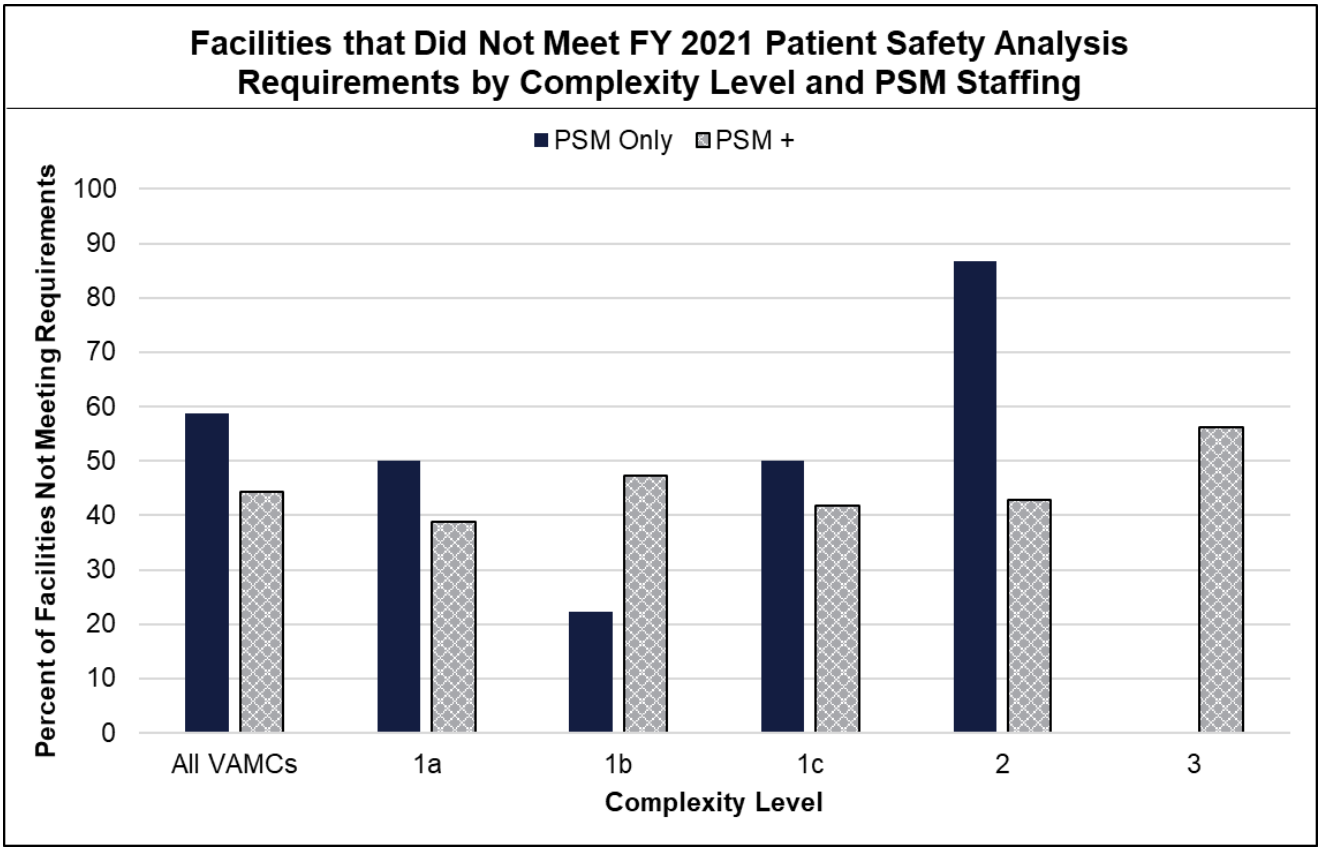

Figure 8. *Patient safety analyses requirement by complexity level and PSM staffing.*
Source: OIG analysis of facility patient safety program data.[73]

Additionally, in FY 2021, 43 percent (32) of facilities that had at least one PSM with time in role of two years or more did not meet the patient safety analyses requirement as compared to, 55 percent (31) of facilities that had all PSMs with less than two years' time in position (see figure 9).

[73] According to the VHA Office of Productivity, Efficiency & Staffing, the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois, is excluded from the complexity model. The analysis for this figure excluded this facility and seven facilities having no PSM respondents.

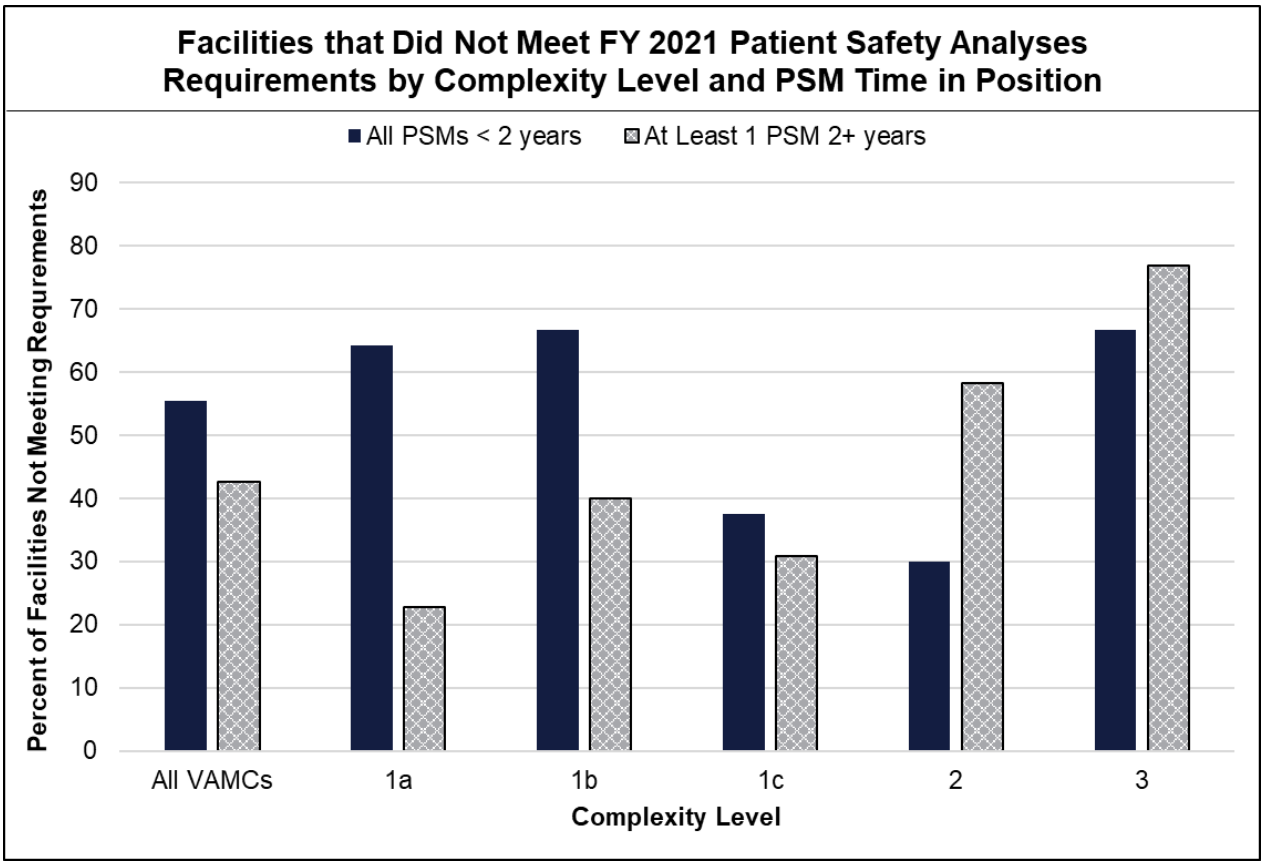

Figure 9. *Patient safety analyses requirement by PSM experience and complexity level.*
Source: OIG analysis of facility patient safety program data.[74]

In written comments to the survey, PSMs described having minimal administrative support to manage a facility's patient safety program as well as other assignments outside of patient safety. Survey respondents indicated that inadequate staffing had a negative impact on the PSMs' ability to fulfill patient safety program requirements, such as JPSR event management and follow-up and RCA completion. [75] Some PSMs commented on having additional duties assisting with implementing their facility's high reliability organization program.

During interviews, PSOs told the OIG of concerns related to facility patient safety program staffing and PSM workload. A PSO explained, "I'm fearful that some facilities are greatly understaffed when you've only got a one man show." One PSO explained the effect of high workload on facility programs, stating "the volume of the workload's just too high to accomplish

[74] According to the VHA Office of Productivity, Efficiency & Staffing, the Captain James A. Lovell Federal Health Care Center in North Chicago, Illinois, is excluded from the complexity model. The analysis for this figure excluded this facility and seven facilities having no PSM respondents.

[75] *VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance*. The PSM is responsible for reviewing JPSR events, determining whether further action, such as an RCA is required, reviewing actions for completeness, and closing the JPSR event.

everything that we want to accomplish." Two PSOs reported that implementation of the new EHR had significantly increased workload.

Further, in interviews with the OIG, eight PSOs reported a high degree of staff turnover in the PSM position. One PSO stated that one facility had three different PSMs in the position over the last year and a half and that the current PSM would be leaving the position to take a different job. Four of the eight PSOs that identified high PSM turnover reported that the turnover caused challenges with ensuring facility compliance with review and completion of JPSR events. One PSO also noted that constant turnover prevented PSMs from "really [having] that true understanding and the working knowledge to get the job done."

The OIG found that approximately half of VHA facilities were unable to meet facility patient safety program analyses requirements in FY 2021. A higher percentage of facilities with PSM only did not meet those requirements as compared to facilities with a PSM plus additional staff. Multiple variables including facility complexity, JPSR event volume, and facility patient safety program staffing impact the ability to meet VHA Patient Safety Program requirements and expectations. All factors must be considered in structuring a patient safety program staffing model.

VISN Patient Safety Program Staffing

The OIG surveyed PSOs to assess current staffing within the VISN patient safety programs. As part of VISN patient safety programs, PSOs should conduct facility patient safety program reviews, have oversight over facility patient safety programs including monitoring the quality and progress of patient safety analyses and actions, and are responsible for tracking and trending patient safety events reported across their VISN [76] Fourteen PSO respondents, indicated they were assigned as the PSO full-time, and two respondents indicated they dedicated 50–75 percent of their time to responsibilities of the VISN patient safety program each week. Only two PSOs identified having additional support staff, leaving most PSOs with no additional support staff for the VISN patient safety programs.

During interviews with the OIG, 18 PSOs reported having been in the PSO position from less than six months to greater than 10 years (figure 10). Seven PSOs were in their positions greater than five years and five were a PSO less than one year (see figure 10).

[76] The *National Center for Patient Safety Guidebook for Completing Facility Patient Safety Program Reviews*, October 2021; "VHA VISN XX Network Functional Statement Patient Safety Officer Nurse IV," PSO responsibilities were also identified in a sample description of duties.

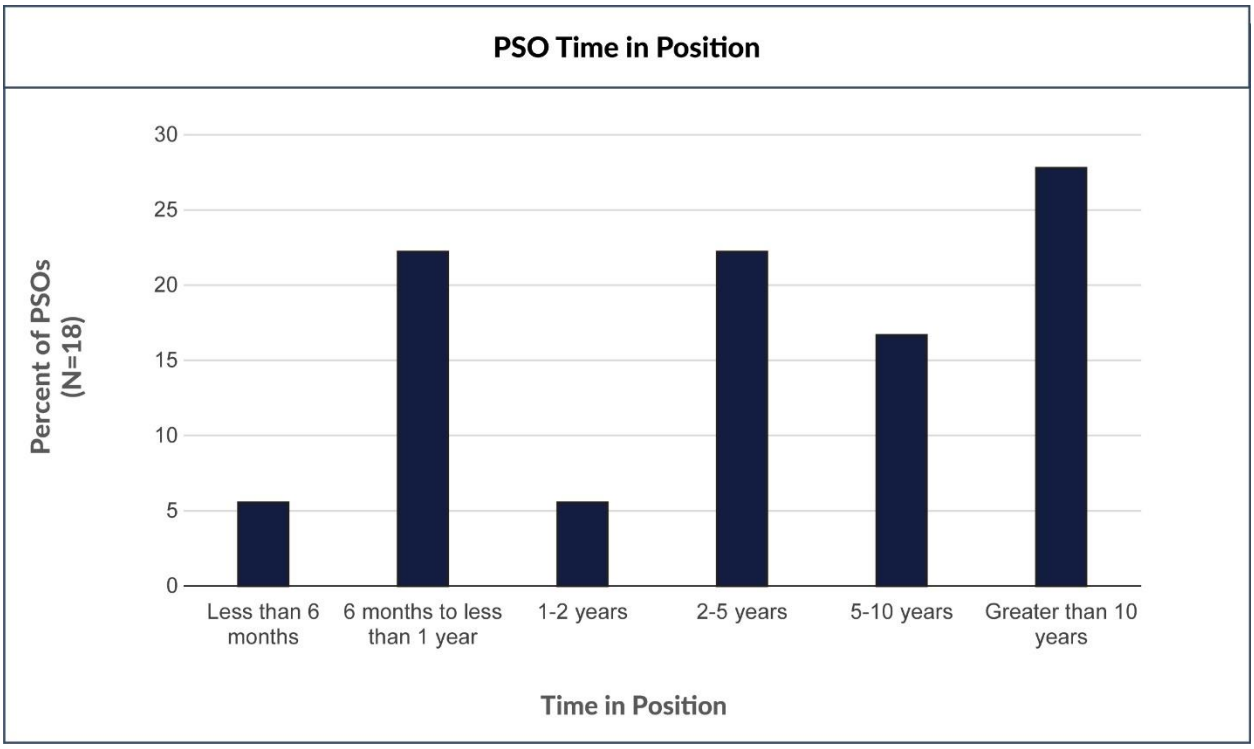

***Figure 10**. VISN patient safety officer time in position.*
Source: OIG analysis of patient safety officer interviews.

A majority of PSOs (12) reported having oversight responsibilities for programs in addition to the VISN patient safety program (see figure 11). One PSO reported they worked as the only staff member in a facility program for seven months in addition to holding responsibilities for the VISN Patient Safety program. The same PSO estimated providing staffing coverage for the equivalent of two and a half to three separate positions in one year.

Figure 11. *Additional patient safety officer program responsibilities by VISN.*
Source: OIG analysis of patient safety officer survey responses and patient safety officer interviews

The OIG concluded that although most PSOs were assigned to their position full-time, most PSOs also had responsibility for other programs in addition to the VISN patient safety program and did not have staff assigned to support the VISN patient safety program. Having assignments for additional programs detracts PSO's time and attention away from VISN patient safety program responsibilities. The OIG would expect NCPS to establish guidance for VISN patient safety program minimum staffing necessary for VISN patient safety program, and oversight and support of facility patient safety programs.[77]

Patient Safety Manager and Patient Safety Officer Burnout

In the PSM survey, 57 percent (105) of the PSMs *agreed* or *strongly agreed* when asked if they felt burnout in their position (see figure 12). Among the PSMs who *agreed* or *strongly agreed*,

[77] VHA Handbook 1050.01, March 4, 2011; VHA Directive 1050.01, March 24, 2023. VHA Directive 1050.01 includes PSO responsibilities and identifies that the VISN Network Director has responsibility to assign one full-time equivalent PSO position.

fifty-two percent (55) indicated having had no opportunity to address the burnout they experienced.

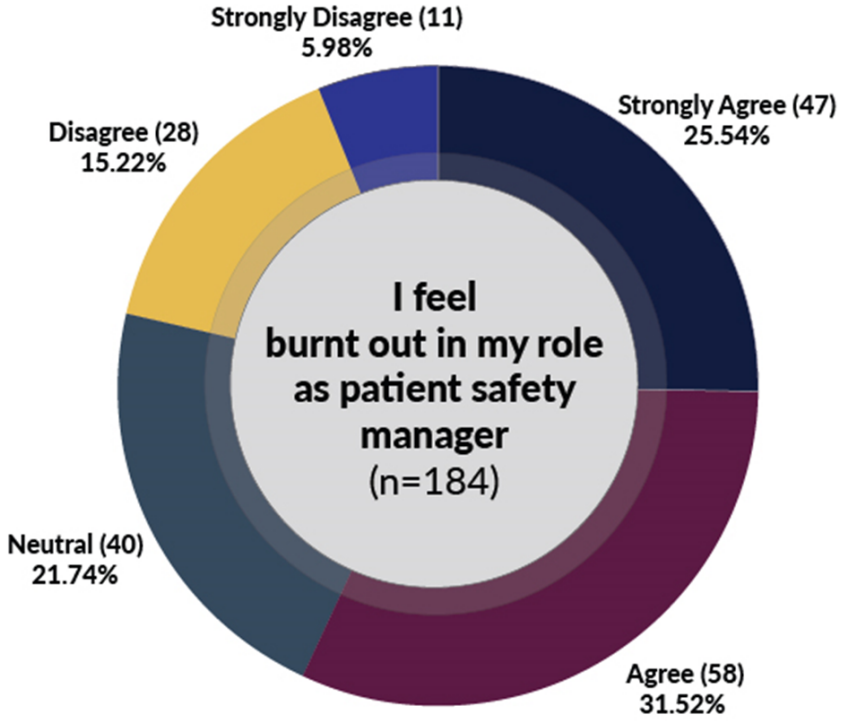

***Figure 12**. Patient safety manager burn out.*
Source: OIG analysis of patient safety manager survey responses.

The Environmental Scan Phase II determined that an array of assigned duties and a heavy workload puts patient safety managers at risk for burnout and increases the risk of turnover.[78] In written comments to the survey, PSMs identified several factors contributing to burnout, including poor engagement or lack of support from facility leaders and staff, difficulty managing workload due to program requirements and insufficient staffing, and the burden of collateral duties outside program requirements.

Similar to survey findings related to the PSMs, PSOs also reported some degree of burnout, with 33 percent (6) of PSOs that received the survey reported they *agreed* or *strongly agreed* when asked if they feel burnt out in their role (see figure 13).

[78] VHA Office of Quality, Safety, and Value, Optimizing Healthcare Value Program, National Center for Patient Safety (NCPS) Patient Safety Environmental Scan Phase II, Initiative I Final Report, June 8, 2022.

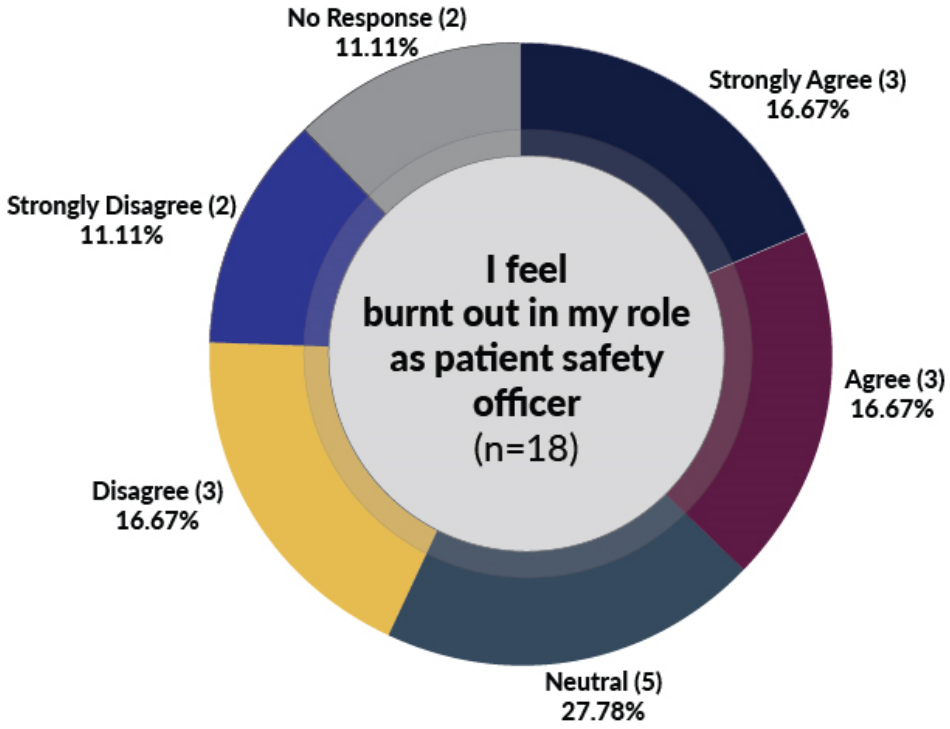

***Figure 13**. Patient safety officer burn out.*
Source: OIG analysis of patient safety officer survey responses.

The PSOs identified that high workload, including collateral duties and coverage of other programs; a lack of administrative support; the need to provide training to PSMs; and an absence of standardized goals or direction from NCPS contributed to PSO burnout.

The OIG concluded that the high percentage of respondents reporting feelings of burnout related to PSM and PSO roles suggests that burnout is an important issue within the patient safety program and that VHA must take further actions to address possible causes. Given the factors contributing to burnout identified by the PSMs, the OIG is concerned that burnout and frequent turnover in PSM positions may continue. PSO burnout may also increase due to oversight of multiple programs and increased facility patient safety program support needed with frequent PSM turnover.

4. Patient Safety Officer and Patient Safety Manager Training

The OIG asked PSMs and PSOs survey questions to understand to what extent VHA has provided educational support to staff working in the roles. This section discusses findings related to the training of PSMs and PSOs from the surveys and information obtained during interviews.

To be successful, healthcare systems are dependent on the performance of each individual employee within the organization. By providing adequate training to employees, healthcare systems help develop the skills, knowledge, and abilities that both motivate employees and result

in higher employee performance. PSMs and PSOs require specialized skills and knowledge of VHA and facility structure and processes. Training provides an opportunity to develop and strengthen patient safety skills and knowledge.

Although VHA recommends training for PSMs and other staff involved in patient safety activities, there are no formalized or standardized training requirements for PSMs and PSOs. VHA Handbook 1050.01 states,

> Training is highly recommended for all Patient Safety Managers (PSM) and other identified key staff involved in RCAs to complement the contents of this Handbook; reading it alone is not sufficient to achieve maximum desired outcomes. Experience has shown that individuals who have not undergone appropriate training have been unable to perform in a consistent and adequate manner.[79]

During interviews, PSOs described a steep learning curve for new PSMs and identified the need to develop necessary skills, including learning the JPSR system and patient safety alert computer software, adapting to a systems approach way of thinking, and effectively building relationships with leaders across organizational lines.

The OIG asked survey respondents to indicate the topics included in patient safety training received as a PSM. None of the PSMs surveyed reported they received no training for their position (see table 2).[80]

[79] VHA Handbook 1050.01; VHA Directive 1050.01. Neither of the two policies specify requirements related to PSM and PSO patient safety training.

[80] Respondents were provided the option to select *no training*.

Table 2. Patient Safety Manager Training

Training Topic	Received Training	Received Training (percent)
High Reliability Organization	156	85%
JPSR System	148	80%
RCA	142	77%
Safety Assessment Code	139	76%
Just Culture	138	75%
SPOT	122	66%
VHA Patient Safety Program Requirements	120	65%
Patient Safety Improvement 101 (NCPS)[81]	117	64%
Sentinel Events and Reporting	112	61%
Healthcare Failure Mode and Effect Analysis	112	61%
VHA Directives/Memoranda	100	54%
Community Care Patient Safety Guidebook	79	43%
Patient Safety 201 (NCPS)[82]	68	37%
Measuring/Monitoring Adverse Events	65	35%
Patient Safety Indicators (Metrics)	56	30%
Other VHA Patient Safety Training	33	18%

Source: OIG analysis of patient safety manager survey responses.

The OIG also surveyed PSOs to better understand the type of educational support provided by VHA to staff working in the role. Of the survey respondents, all PSOs reported receiving some training for their position (see table 3).[83]

Table 3. Patient Safety Officer Training

Training Topic	Received Training	Received Training (percent)
High Reliability Organization	16	100%
Just Culture	16	100%

[81] Patient Safety Improvement 101 is a learning program provided by the NCPS that includes patient safety concepts, processes, and policies designed for patient safety and quality improvement professionals.

[82] Patient Safety 201 is a learning program provided by the NCPS that includes tools, techniques, and skills to develop patient safety leaders.

[83] Respondents were provided the option to select *no training*. None of the 16 respondents indicated receiving no training while in the PSO position.

Training Topic	Received Training	Received Training (percent)
VHA Patient Safety Program Requirements	16	100%
Safety Assessment Code	16	100%
Healthcare Failure Mode and Effect Analysis	16	100%
JPSR System	15	94%
RCA	14	88%
VHA Directives/Memoranda	13	81%
Patient Safety Improvement 101 (NCPS)	13	81%
Patient Safety 201 (NCPS)	13	81%
Other VHA Patient Safety Training	12	75%
Sentinel Events and Reporting	12	75%
SPOT	12	75%
Measuring/Monitoring Adverse Events	7	44%
Patient Safety Indicators (Metrics)	6	38%

Source: OIG analysis of patient safety officer survey responses.
Note: A total of 18 PSO surveys were distributed, this table does not include the two PSOs that did not respond to the survey.

Adequacy of Patient Safety Manager Training

PSMs were also asked a survey question about whether training they received adequately prepared them for the positions. Of the 184 survey respondents, 44 percent (81) of PSMs *agreed* or *strongly agreed* that training received was adequate. (see figure 14).

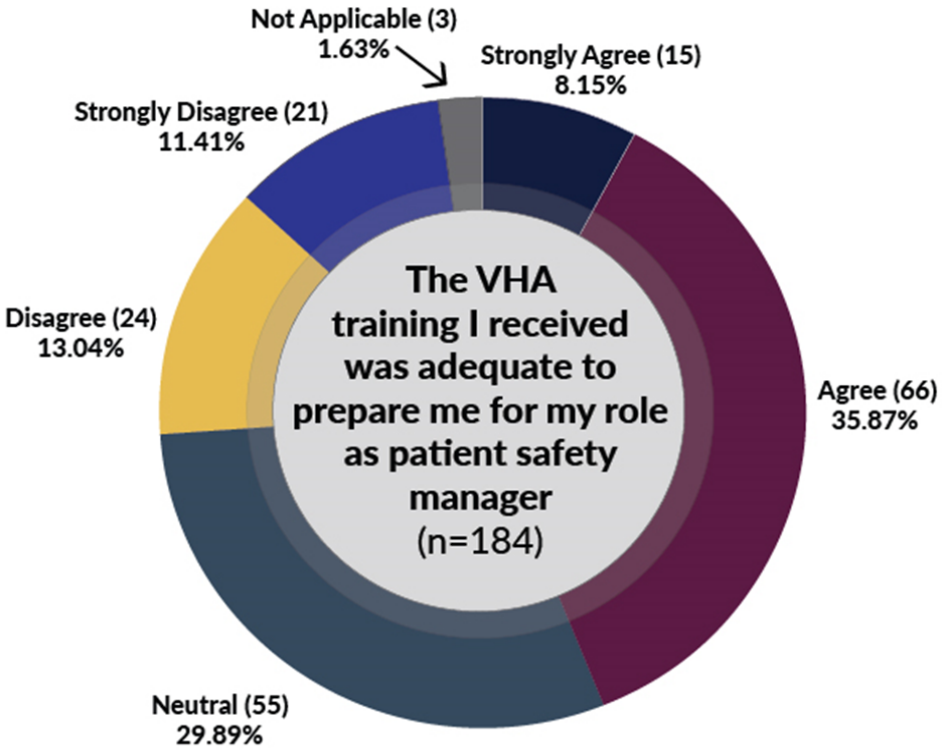

Figure 14. *Adequacy of patient safety manager training.*
Source: OIG analysis of patient safety manager survey responses.
Note: Total does not equal 100 percent because numbers were rounded to the nearest hundredth.

PSMs who answered *disagree* or *strongly disagree* about whether training they received adequately prepared them for the PSM role, provided additional comments that reflected the respondents' views as to the insufficiency of patient safety training. Respondents reported that the training received was "limited" and "on-the-job" and described being unprepared to complete the many facility patient safety program responsibilities. PSMs commented that the training received lacked the depth needed to effectively perform program requirements, such as JPSR and RCA. PSMs identified training was delayed or reported not receiving any formal training after taking the position as PSM. In the survey, most PSMs indicated receiving training from either PSOs or other PSMs.[84] Among 115 PSMs who reported having received training from PSOs, sixty-three percent (73) of respondents answered *agree* or *strongly agree* when asked if the training provided by PSOs was adequate. However, 10 percent (12) of PSMs who selected *disagree* or *strongly disagree* described concerns including PSOs lacked the necessary knowledge and expertise to provide guidance to PSMs, no formal standardization in curriculum, partial information provided about topics relevant to program requirements, and technical

[84] Twenty-eight PSMs indicated not receiving training from either PSOs or other PSMs.

difficulties during virtual training sessions. Of 119 PSMs who reported having received training from other PSMs, 22 percent (26) *disagreed* that the training was adequate, and some respondents reported the PSMs who provided the training were inexperienced or lacked adequate training.

In the survey, the OIG asked PSMs to provide recommendations for improving patient safety training. PSMs identified a need to create structured or formalized training content that includes more scenario-based training on program requirements. PSMs reported a need for more frequent or continuous education training pertinent to their role.

Additionally, PSMs reported other training that would be valuable, including patient safety program requirements such as a healthcare failure mode effect analysis. PSMs also indicated the need for additional training on the use of program data along with tools used for data analysis.

Responsibility for Patient Safety Manager Training

The OIG conducted interviews with PSOs and the NCPS Executive Director and reviewed related documents to better understand the responsibilities for PSM training.

NCPS stopped providing Patient Safety Improvement 101 and Patient Safety 201 training in 2019 with no alternative training place, leaving the PSOs with the responsibility of training new and current PSMs.[85] When the OIG asked PSOs to identify who is currently responsible for providing PSM training, four PSOs indicated a shared responsibility between the facility and the PSO, nine PSOs stated the training was the responsibility of the PSO, two indicated the responsibility was shared between the PSO and NCPS, two PSOs indicated NCPS is responsible, and one PSO indicated the responsibility was unclear. One PSO stated, "I don't really honestly have the bandwidth to do [training]." One PSO mentioned that PSMs want to hear from NCPS, they want to "hear from the authorities." The PSO mentioned that PSMs and PSOs are starting to get support back from NCPS, to include training, and both the PSO and PSMs are appreciative of the support.

PSOs also reported that in the absence of NCPS patient safety training, PSOs developed and provided training through the Patient Safety Program Academy. One PSO reported that PSOs provided the Patient Safety Program Academy training virtually over the course of six to eight weeks that included a 42-hour curriculum on various patient safety topics. New PSMs attended the Patient Safety Program Academy as a means of fulfilling what the PSOs perceived as training requirements.

[85] NCPS staff confirmed with the OIG that NCPS provided the final Patient Safety Improvement 101 training in September 2019 and final Patient Safety 201 training in March 2019. In an interview, the NCPS Executive Director told the OIG that the previous NCPS Executive Director made the decision to halt patient safety education, and instead chose to focus NCPS efforts on research, publication, and policy.

Several PSOs reported providing training for PSMs in their VISN and using an orientation checklist when training PSMs. The PSOs reported that NCPS published the PSM Orientation Checklist as a resource.[86] The OIG reviewed the checklist that included the following topics:

- access required for patient safety databases, such as JPSR system
- VHA Patient Safety Program requirements
- management of patient safety events
- conducting patient safety analyses, such as RCA and proactive risk assessment
- management of national alerts and product recalls
- applicable VHA measures

The OIG opined that the method for assessing PSM understanding of some elements in the orientation checklist was unclear and allowed for variance in understanding by new PSMs. The unclear methods of verification for assessment of patient safety topics on the orientation checklist include "discussion," "VISN specific," "local process," "awareness," and "review web sites."[87]

The Environmental Scan Phase II published in June 2022 identified gaps in expertise of patient safety staff, including PSMs, within VHA.[88] The environmental scan highlighted concerns regarding the lack of experience of individuals hired for patient safety roles and a lack of training available for new patient safety staff. Associated performance gaps for patient safety staff with a lack of standardized training curriculum is also identified as a challenge.

During interviews, the NCPS Executive Director reported that, although Patient Safety Improvement 101 and Patient Safety 201 training was currently on hold, in fiscal year 2023, NCPS will provide the Patient Safety Program Academy training.[89] The NCPS Executive Director also reported that NCPS plans to add educational opportunities, through the use of

[86] NCPS, "Patient Safety Manager (PSM) Orientation Checklist FY2022, [Version 2–September 2022]," accessed October 27, 2022, https://dvagov.sharepoint.com/:w:/r/sites/vhancps/Shared%20Documents/Patient%20Safety%20Professionals%20Position%20and%20Mentoring%20Resources/Patient%20Safety%20Professionals%20Orientation%20Checklist_v4_Feb2023.docx?d=w764b53f37a9b4d0cbbeaa5ec9a2adff7&csf=1&web=1&e=b2sesV. (This site is not publicly accessible.)

[87] NCPS, "Patient Safety Manager (PSM) Orientation Checklist FY2022 [Version 2–September 2022]."

[88] VHA Office of Quality, Safety and Value, Optimizing Healthcare Value Program, National Center for Patient Safety (NCPS) Patient Safety Environmental Scan Phase II, Initiative I Final Report.

[89] The OIG received confirmation from an NCPS staff member that starting in January 2023, NPCS began providing Patient Safety Program Academy training.

office hour conference calls for PSMs and PSOs and RCA training.[90] The PSOs reported positive changes at NCPS including the following:

- increased engagement with the field (PSO and PSM)
- implementation of NCPS office hours
- improvement in training offerings
- improvement in communication
- development of tools and guides

Adequacy of Patient Safety Officer Training

In the survey PSOs were asked whether training received adequately prepared them for the role. A majority of PSOs, 56 percent (10), either *agreed* or *strongly agreed* that VHA training received was adequate to prepare them for their role as PSO (see figure 15).

[90] The Executive Director, NCPS told the OIG that the NCPS initiated office hour conference calls with PSOs and PSMs as a mechanism to communicate updates.

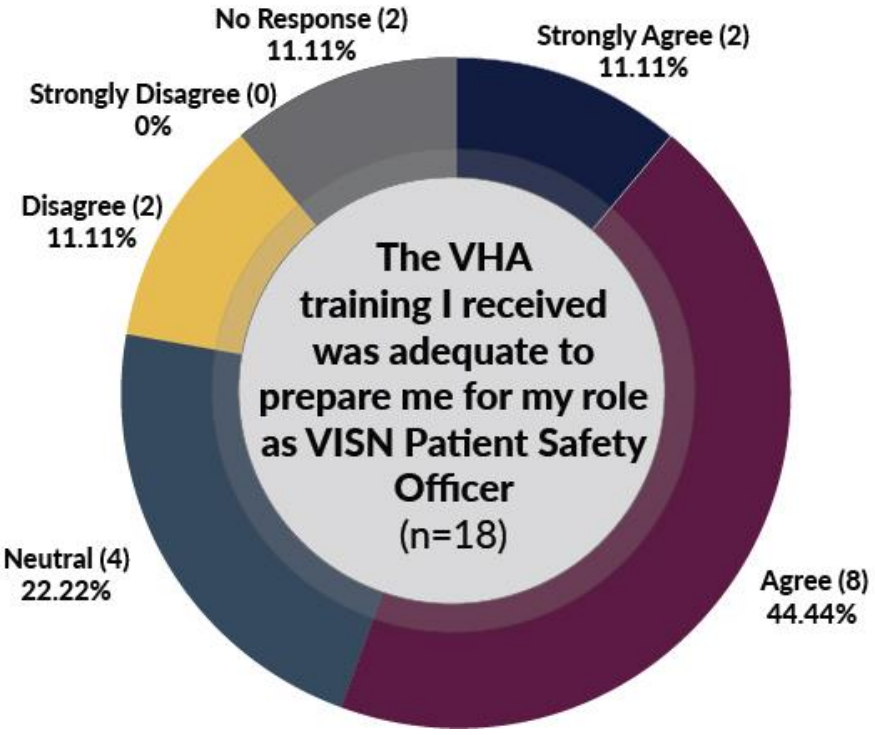

***Figure 15**. Adequacy of patient safety officer training.*
Source: OIG analysis of patient safety officer survey responses

Two out of the 16 PSOs surveyed provided comments to this question. One PSO reported never serving in the role of a PSM. The PSO also described their learning process about patient safety as "self-driven" and noted that having a dedicated VISN resource person would have prevented them from spending "hours looking for answers." The PSO reported that, while NCPS provides handbooks and guidebooks, there is no PSO orientation or training program. The other PSO described years of prior PSM experience preparing them for the role. Also, the second PSO stated that VISN leadership training and mentoring would be valuable to the PSO role.

The OIG concluded that there are opportunities to improve job training for PSMs and PSOs to include standardized, initial, and continuing formal training. Patient safety is an important healthcare topic that requires specialized training for patient safety professionals tasked with leading facility and VISN patient safety programs.

Conclusion

Concerns related to patient safety are a recurring topic in many OIG oversight reports. The OIG conducted a national survey of PSMs and a separate survey of PSOs and interviewed VHA quality and patient safety leaders and 18 PSOs to assess their responsibilities and oversight of facility patient safety programs.

Based on the analysis of the survey results and interview information, the OIG found variabilities in NCPS and VISN oversight of facility patient safety programs and facility patient safety program staffing. Additionally, VISN and facility staff identified barriers to fostering strong safety culture and providing standardized patient safety training.

NCPS develops quarterly reports which contain facility patient safety data collected from the JPSR system and other VHA data sources. The OIG determined that while the quarterly reports included patient safety program data such as volume of JPSR events reported and patient safety analyses completed, they did not provide a qualitative analysis of patient safety data. During an interview, the VHA's Assistant Under Secretary for Health for Quality and Patient Safety told the OIG of streamlining the quarterly reports to make the quarterly reports more useful to staff who receive the reports. The OIG agrees that a shift to include an analysis of patient safety data in the quarterly reports would be helpful to staff. A focus on using data to drive process changes can lower or have potential to lower risk of patient harm.

The *VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance* states that VISN PSOs are responsible for overseeing that facilities monitor and investigate JPSR events and that PSOs "will review a subset of all [JPSR] event reports" but does not define the frequency or volume of the reviews required. During interviews, the OIG found that although all PSOs reported having processes to provide oversight of the implementation and quality of facility patient safety programs within each VISN, there was variability in oversight practices, which include the frequency and volume of reviews required.

PSOs stated that barriers to meeting with third-party administrators included inconvenient meeting times, not being included in meeting invitations, and third-party administrators not agreeing to or declining to meet.

Twelve of the 16 PSOs who responded to the PSO survey either *agreed* or *strongly agreed* with the statement "Patient safety is a VISN priority that is considered in decision making processes." Most PSMs surveyed reported receiving support from facility executive leaders when an adverse event occurred. However, comments provided by PSMs identified limited communication which may inhibit their ability to build trusted relationships if left unaddressed by facility leaders.

The OIG found that all facilities with responses were staffed with at least one PSM and some facilities had additional staff assigned to patient safety. However, in written comments to the survey, PSMs described having minimal administrative support to manage a facility's patient safety program as well as other assignments outside of patient safety such as assisting with implementation of their facility's high reliability organization program. Respondents also indicated that inadequate staffing had a negative impact on the PSMs' ability to fulfill patient safety program requirements, such as JPSR event management and follow-up and RCA completion.

The OIG found that high and medium complexity level facilities (1b, 1c, and 2) with a PSM plus additional staff had a lower average percentage of overdue JPSR events than facilities with only one PSM. In addition, the OIG found that facilities that have a PSM and additional staff achieved a higher level of compliance with completing a minimum of eight patient safety analyses annually.

Multiple variables including facility complexity, JPSR event volume, and facility patient safety program staffing impact the ability to meet VHA Patient Safety Program requirements and expectations. All factors must be considered in structuring a patient safety program staffing model.

Twelve PSOs reported having oversight responsibilities for programs in addition to the VISN patient safety program. Having assignments for additional programs detracts PSO's time and attention away from VISN patient safety program responsibilities.

The OIG found that 57 percent of PSMs (105) and 33 percent of PSOs (6) reported feelings of burnout in their positions. These high percentages suggest that burnout is an important issue within the patient safety program and that VHA must take further actions to address possible causes.

PSMs and PSOs require specialized skills, and knowledge of VHA and facility structure and processes. Although VHA recommends training for PSMs and other staff involved in patient safety activities, there are no formalized or standardized training requirements for PSMs and PSOs.

No PSM and PSO survey respondents reported receiving no training for their position. However, only 44 percent (81) of PSMs and 56 percent (10) of PSOs affirmed that training received adequately prepared them for their positions. The OIG concluded that there are opportunities to improve job training for PSMs and PSOs to include standardized initial and continuing formal training.

Recommendations 1–9

1. The Assistant Under Secretary for Health for Quality and Patient Safety establishes facility patient safety program oversight requirements for patient safety officers to include minimum frequency and volume of oversight activities and expectations for follow-up when patient safety program deficiencies are identified.

2. The National Center for Patient Safety Executive Director evaluates the National Center for Patient Safety quarterly reports, includes an analysis of patient safety data in the reports, and establishes a mechanism for National Center for Patient Safety, in conjunction with Veteran Integrated Service Networks, to direct interventions to promote improvements when facility patient safety program requirements are not met or if deemed necessary to enhance patient safety programs.

3. The Under Secretary for Health evaluates barriers to communication between third-party administrators and patient safety officers and takes action as needed to resolve barriers.

4. The Assistant Under Secretary for Health for Quality and Patient Safety evaluates barriers that limit engagement between Veteran Integrated Service Network and facility directors and patient safety officers and patient safety managers.

5. The National Center for Patient Safety Executive Director develops a patient safety program staffing configuration for patient safety managers to include facility complexity and patient safety program requirements with recurring reassessment and revision based on requirement changes.

6. The National Center for Patient Safety Executive Director establishes staffing guidance for Veteran Integrated Service Network patient safety programs to include facility complexity and workload from other assigned responsibilities to ensure prioritization of patient safety officer oversight and support of facility patient safety programs.

7. The National Center for Patient Safety Executive Director establishes processes to evaluate factors contributing to patient safety managers and patient safety officers' burnout, including patient safety manager turnover, and implements actions as needed to address burnout.

8. The National Center for Patient Safety Executive Director evaluates patient safety manager and patient safety officer training and implements standardized formalized training with requirements for newly appointed patient safety managers and newly appointed patient safety officers to include time frames and completion.

9. The National Center for Patient Safety Executive Director establishes standardized continuing education requirements to meet the training needs for patient safety managers and patient safety officers.

Appendix A: VA OIG Healthcare Inspection Reports

Hotline Healthcare Inspection Report	Publication Date
Multiple Failures in Test Results Follow-up for a Patient Diagnosed with Prostate Cancer at the Hampton VA Medical Center in Virginia, Report 21-03349-186	June 28, 2022
Deficiencies in Disclosures and Quality Processes for Perforations Resulting from Urological Surgeries at West Palm Beach VA Medical Center in Florida, Report 21-01049-39	December 9, 2021
Delayed Cancer Diagnosis of a Veteran Who Died at the Raymond G. Murphy VA Medical Center in Albuquerque, New Mexico, Report 20-03700-35	November 23, 2021
Deficiencies in COVID-19 Screening and Facility Response for a Patient Who Died at the Michael E. DeBakey VA Medical Center in Houston, Texas, Report 20-03635-217	August 18, 2021
Failures in Care Coordination and Reviewing a Patient's Death at the VA Salt Lake City Healthcare System in Utah, Report 21-00657-197	July 29, 2021
Audiology Leaders' Deficiencies Responding to Poor Care and Monitoring Performance at the Eastern Oklahoma Health Care System in Muskogee, Report 20-04341-182	July 21, 2021
Improper Feeding of a Community Living Center Patient Who Died and Inadequate Review of the Patient's Care, VA New York Harbor Healthcare System in Queens, Report 20-02968-170	June 22, 2021
Pathology Oversight Failures at the Veterans Health Care System of the Ozarks, Fayetteville, Arkansas, Report 18-02496-157	June 2, 2021
Care and Oversight Deficiencies Related to Multiple Homicides at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia, Report 20-03593-140	May 11, 2021
Deficiencies in Community Living Center Practices and the Death of a Patient Following Elopement from the Chillicothe VA Medical Center in Ohio, Report 20-01523-102	May 6, 2021
Insufficient Veterans Crisis Line Management of Two Callers with Homicidal Ideation, and an Inadequate Primary Care Assessment at the Montana VA Health Care System in Fort Harrison, Report 20-00545-115	April 15, 2021
Thoracic Surgery Quality of Care Issues and Facility Leaders' Response at the C.W. Bill Young VA Medical Center in Bay Pines, Florida, Report 18-01321-56	January 13, 2021
Deficiencies in Inpatient Mental Health Care Coordination and Processes Prior to a Patient's Death by Suicide, Harry S. Truman Memorial Veterans' Hospital in Columbia, Missouri, Report 20-01521-48	January 5, 2021

Surgical Service Care Deficiencies in the Critical Care Unit at the Charlie Norwood VA Medical Center in Augusta, GA, Report 20-01480-31	December 16, 2020
Deficiencies in the Veterans Crisis Line Response to a Veteran Caller Who Died, Report 19-08542-11	November 17, 2020
Management of the Ophthalmology Clinic and Patient Safety Reporting Concerns at the VA Central Iowa Health Care System in Des Moines, Report 20-01326-08	November 3, 2020
Deficiencies in Pharmacy and Nursing Processes at the Southeast Louisiana Veterans Health Care System in New Orleans, Report 19-07854-272	September 29, 2020
Deficiencies in Care, Care Coordination, and Facility Response to a Patient who Died by Suicide, Memphis VA Medical Center in Tennessee, Report 19-09493-249	September 3, 2020
Facility Oversight and Leaders' Responses Related to the Deficient Practice of a Pathologist at the Hunter Holmes McGuire VA Medical Center in Richmond, Virginia, Report 19-07600-215	July 29, 2020
Anesthesia Provider Practice Concerns at the W.G. (Bill) Hefner VA Medical Center in Salisbury, North Carolina, Report 19-09377-192	July 2, 2020
Deficiencies in the Women Veterans Health Program and Other Quality Management Concerns at the North Texas VA Healthcare System, Dallas, Texas, Report 19-06378-73	January 23, 2020
Deficiencies in Care Coordination and Facility Response to a Patient Suicide at the Minneapolis VA Health Care System, Minnesota, Report 19-00468-67	January 7, 2020
Alleged Deficiencies in Oncology Psychosocial Distress Screening and Root Cause Analysis Processes at a Facility in Veterans Integrated Service Network 15, Report 19-06562-30	December 11, 2019
Facility Hiring Processes and Leaders' Reponses Related to the Deficient Practice of a Radiologist at the Charles George VA Medical Center, Asheville, North Carolina, Report 18-05316-234	September 30, 2019
Quality of Care and Patient Safety Concerns on the Acute Behavioral Health Unit at the Corporal Michael J. Crescenz VA Medical Center, Philadelphia, Pennsylvania, Report 18-00777-224	September 19, 2019
Facility Leaders' Oversight and Quality Management Processes at the Gulf Coast VA Health Care System, Biloxi, Mississippi, Report 17-03399-200	August 28, 2019
Pathology Processing Delays at the Memphis VA Medical Center, Tennessee, Report 18-02988-198	August 27, 2019
Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center, Florida, Report 19-07429-195	August 22, 2019
Factors Contributing to the Death of a Ventilator-Dependent Patient at the VA San Diego Healthcare System, California, Report 19-06386-179	July 30, 2019

Concerns Related to an Inpatient's Response to Oxycodone and Facility Actions at the Baltimore VA Medical Center, Maryland, Report 18-05731-176	July 29, 2019
Leadership, Clinical, and Administrative Concerns at the Charlie Norwood VA Medical Center, Augusta, Georgia, Report 19-00497-161	July 11, 2019
Comprehensive Healthcare Inspection Report	**Publication Date**
Comprehensive Healthcare Inspection of the VA Caribbean Healthcare System in San Juan, Puerto Rico, Report 21-00270-04	October 26, 2021
Comprehensive Healthcare Inspection of the Mann-Grandstaff VA Medical Center in Spokane, Washington, Report 20-01262-191	August 4, 2021
Comprehensive Healthcare Inspection of the Roseburg VA Health Care System in Oregon, Report 20-01259-196	August 2, 2021
Comprehensive Healthcare Inspection of the VA Puget Sound Health Care System in Seattle, Washington, Report 20-01261-194	July 28, 2021
Comprehensive Healthcare Inspection of the VA Portland Health Care System in Oregon, Report 20-01257-180	July 13, 2021
Comprehensive Healthcare Inspection of the Chillicothe VA Medical Center in Ohio, Report 20-01268-143	May 27, 2021
Comprehensive Healthcare Inspection of the Cincinnati VA Medical Center in Ohio, Report 20-01276-131	May 19, 2021
Comprehensive Healthcare Inspection of the Charlie Norwood VA Medical Center in Augusta, Georgia, Report 20-00132-28	December 16, 2020
Comprehensive Healthcare Inspection of the Birmingham VA Medical Center in Alabama. Report 20-00130-241	September 10, 2020
Comprehensive Healthcare Inspection of the Central Alabama Veterans Health Care System in Montgomery, Report 20-00131-243	September 10, 2020
Comprehensive Healthcare Inspection of the Robert J. Dole VA Medical Center in Wichita, Kansas, Report 19-06872-199	August 18, 2020
Comprehensive Healthcare Inspection of the VA St. Louis Health Care System in Missouri, Report 19-06873-210	August 12, 2020
Comprehensive Healthcare Inspection of the Kansas City VA Medical Center in Missouri, Report 19-06850-208	July 23, 2020
Comprehensive Healthcare Inspection of the Harry S. Truman Memorial Veteran's Hospital in Columbia, Missouri, Report 19-06864-183	July 9, 2020
Comprehensive Healthcare Inspection of the VA Eastern Kansas Health Care System in Topeka, Report 19-06870-175	June 18, 2020
Comprehensive Healthcare Inspection of Veterans Integrated Service Network 1: VA New England Healthcare System, Bedford, Massachusetts, Report 19-06866-68	January 29, 2020

Comprehensive Healthcare Inspection of the Alaska VA Healthcare System, Anchorage, Alaska, Report 19-00054-72	January 28, 2020
Comprehensive Healthcare Inspection of the West Texas VA Health Care System, Big Spring, Texas, 19-00034-62	January 15, 2020
Comprehensive Healthcare Inspection of the Richard L. Roudebush VA Medical Center, Indianapolis, Indiana, Report 19-00012-51	January 14, 2020
Comprehensive Healthcare Inspection of the VA Central Western Massachusetts Healthcare System, Leeds, Massachusetts, Report 19-00038-63	January 13, 2020
Comprehensive Healthcare Inspection of the Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts, Report 19-00043-66	January 13, 2020
Comprehensive Healthcare Inspection of the VA Maryland Health Care System, Baltimore, Maryland, Report 19-00016-61	January 9, 2020
Comprehensive Healthcare Inspection of the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon, Report 19-00052-54	December 19, 2019
Comprehensive Healthcare Inspection of the Chalmers P. Wylie Ambulatory Care Center, Columbus, Ohio, Report 19-00051-40	December 18, 2019
Comprehensive Healthcare Inspection of the Northern Arizona VA Health Care System, Prescott, Arizona, Report 19-00014-33	December 5, 2019
Comprehensive Healthcare Inspection of the Manchester VA Medical Center, New Hampshire, Report 19-00040-10	November 25, 2019
Comprehensive Healthcare Inspection of the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia, Report 18-04679-239	September 27, 2019
Comprehensive Healthcare Inspection of the North Florida/South Georgia Veterans Health System, Gainesville, Florida, Report 19-00010-237	September 27, 2019
Comprehensive Healthcare Inspection of the Tuscaloosa VA Medical Center, Alabama, Report 19-00057-238	September 27, 2019

Source: OIG analysis of prior OIG publications to identify patient safety program recommendations.

Appendix B: Patient Safety Officer and Patient Safety Manager Survey Response

VISN	PSO Survey Response	PSM Survey Response
VISN 1: VA New England Healthcare System	0% (0/1)	92% (11/12)
VISN 2: New York/New Jersey VA Health Care Network	100% (1/1)	86% (12/14)
VISN 4: VA Healthcare – VISN 4	100% (1/1)	83% (10/12)
VISN 5: VA Capitol Health Care Network	0% (0/1)	83% (5/6)
VISN 6: VA Mid-Atlantic Health Care Network	100% (1/1)	100% (9/9)
VISN 7: VA Southeast Network	100% (1/1)	100% (9/9)
VISN 8: VA Sunshine Healthcare Network	100% (1/1)	88% (7/8)
VISN 9: VA MidSouth Healthcare Network	100% (1/1)	100% (5/5)
VISN 10: VA Healthcare System	100% (1/1)	90% (18/20)
VISN 12: VA Great Lakes Health Care System	100% (1/1)	71% (10/14)
VISN 15: VA Heartland Network	100% (1/1)	77% (10/13)
VISN 16: South Central VA Health Care Network	100% (1/1)	80% (12/15)
VISN 17: VA Heart of Texas Health Care Network	100% (1/1)	86% (6/7)
VISN 19: Rocky Mountain Network	100% (1/1)	88% (14/16)
VISN 20: Northwest Network	100% (1/1)	88% (14/16)
VISN 21: Sierra Pacific Network	100% (1/1)	92% (12/13)
VISN 22: Desert Pacific Healthcare Network	100% (1/1)	93% (13/14)
VISN 23: VA Midwest Health Care Network	100% (1/1)	88% (7/8)
All Surveys	89% (16/18)	87% (184/211)

Source: OIG analysis of patient safety officer and patient safety manager survey responses

Appendix C: Education and Training Background of Patient Safety Managers

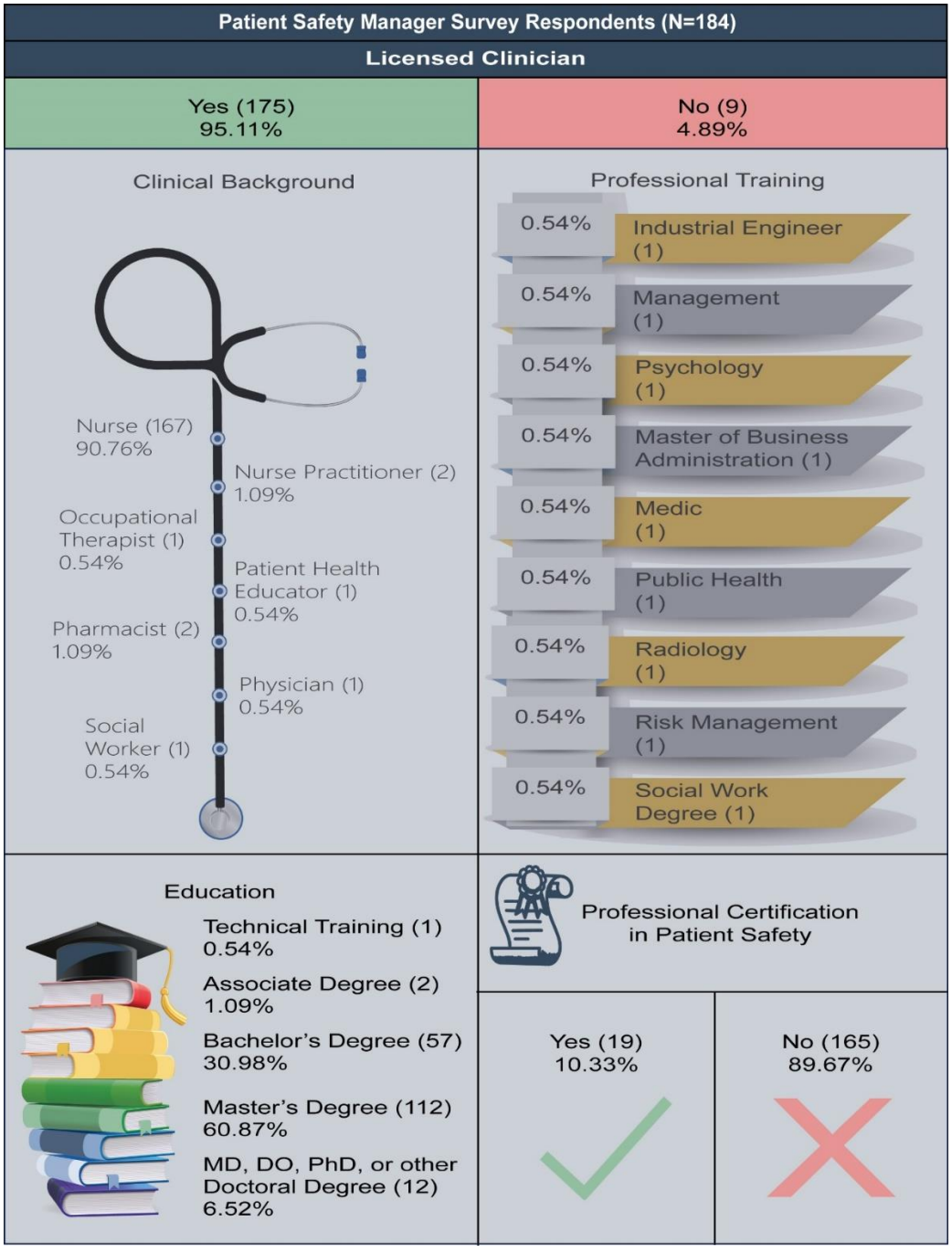

Figure 16. *Education and training background of patient safety managers.*
Source: OIG analysis of patient safety manager survey responses
Note: Some percentages do not equal total percentage due to rounding.

Appendix D: Office of the Under Secretary for Health

Department of Veterans Affairs Memorandum

Date: August 17, 2023

From: Under Secretary for Health (10)

Subj: OIG Draft Report, Review of Veterans Health Administration's Multi-Tiered Patient Safety Program (Project Number # 2022-02377-HI-1263) (VIEWS 10645444)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) draft report, Review of Veterans Health Administration's Multi-Tiered Patient Safety Program. The Veterans Health Administration (VHA) concurs with the recommendations and provides an action plan in the attachment.

2. Ensuring that Veterans receive highest-quality and safest care possible is the cornerstone of our work in VHA and, as an organization committed to high reliability, we appreciate and take seriously all opportunities to improve. We are grateful for our dedicated patient safety professionals in VHA and appreciate the OIG's review. As a foundational step to address many of the challenges identified in the OIG's report, VHA published policy in March 2023 that further strengthens our patient safety operations. This policy establishes patient safety program oversight requirements for patient safety officers (PSO) to include "conducting program assessments of the structure, work and support systems at each VA medical facility in the VISN to determine if additional resources are needed." This policy will be supported by robust tools and guidelines to support an objective program review. Additionally, this policy sets the expectation that VA medical facility Patient Safety Managers and Veterans Integrated Service Network (VISN) PSOs have "direct access to and participate in executive conversations, such as huddles where a quality and patient safety perspective is necessary." The policy recommends the strong practice of "regularly occurring one-on-one meetings to foster communication and maintain clear awareness of emerging or concerning issues, as well as opportunities for improvement."

3. The Office of Quality and Patient Safety (QPS) started bi-annual engagements with quality, patient safety and VISN leadership teams in fiscal year 2022. In these meetings quality and patient safety data are reviewed, strong practices are shared, and QPS and VISN leadership teams collaboratively work on identifying and addressing challenges. As QPS and VISN leadership teams continue with these successful meetings, policy implementation will be incorporated into those discussions.

4. Strategic initiatives in the National Center for Patient Safety are focused on building the VHA patient safety program based on responsibilities outlined in the new directive. There is an increased effort to advance the knowledge, skills, and abilities of patient safety professionals and to improve partnerships and collaboration with their quality colleagues. Patient Safety is everyone's responsibility, and VHA looks forward to investing in building and expanding that culture to the benefit of the Veterans we serve.

5. 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

Office of the Under Secretary for Health

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan
OIG Draft Report, Review of Veterans Health Administration's Multi-Tiered Patient Safety Program
(OIG 2022-02377-HI-1263)

Recommendation 3. The Under Secretary for Health evaluates barriers to communication between third-party administrators and patient safety officers and takes action as needed to resolve barriers.

VHA Comments: Concur. NCPS will expand its ongoing collaboration with the Office of Integrated Veterans Care (IVC) to address issues related to shared responsibility between IVC and NCPS for ensuring the safety of care that Veterans receive in the community and create an action plan to evaluate and remove barriers to communication between third-party administrators and VHA patient safety professionals.

Status: In progress Target Completion Date: March 2024

Appendix E: Office of the Assistant Under Secretary for Health for Quality and Patient Safety

Department of Veterans Affairs Memorandum

Date: August 9, 2023

From: Office of the Assistant Under Secretary for Health for Quality and Patient Safety (17)

Subj: OIG Draft Report, Review of Veterans Health Administration's Multi-Tiered Patient Safety Program (Project Number # 2022-02377-HI-1263) (VIEWS 10645444)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General draft report, Review of Veterans Health Administration's Multi-Tiered Patient Safety Program. The response to the recommendations made to the Assistant Under Secretary for Health for Quality and Patient Safety is in the memorandum from the Under Secretary for Health.

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:)

Gerard R. Cox, MD, MHA

Office of the Assistant Under Secretary for Health for Quality and Patient Safety Response

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan
OIG Draft Report, Review of Veterans Health Administration's Multi-Tiered Patient Safety Program
(OIG 2022-02377-HI-1263)

Recommendation 1. The Assistant Under Secretary for Health for Quality and Patient Safety establishes facility patient safety program oversight requirements for patient safety officers to include minimum frequency and volume of oversight activities and expectations for follow-up when patient safety program deficiencies are identified.

VHA Comments: Concur. VHA Directive 1050.01, "VHA QUALITY AND PATIENT SAFETY PROGRAMS," published March 2023, assigns responsibility to Veterans Integrated Service Network (VISN) Patient Safety Officers (PSOs) to "conduct program assessments of the structure, work and support systems at each VA medical facility in the VISN to determine if additional resources are needed." The Assistant Under Secretary for Health (AUSH) for Quality and Patient Safety (QPS) will define patient safety program requirements for PSOs, including frequency and volume of oversight activities and expectations for addressing deficiencies. Updated guidelines will be communicated to the PSOs through formal channels.

Status: In progress Target Completion Date: December 2023

Recommendation 4. The Assistant Under Secretary for Health for Quality and Patient Safety evaluates barriers that limit engagement between Veteran Integrated Service Network and facility directors and patient safety officers and patient safety managers.

VHA Comments: Concur. VHA Directive 1050.01 specifies that VA medical facility Patient Safety Managers (PSMs) and VISN PSOs must have "direct access to and participate in executive conversations, such as huddles where a quality and patient safety perspective is necessary." The AUSH for QPS will develop an assessment tool to evaluate compliance with that expectation as well as other responsibilities outlined in the directive, then trend and analyze responses from those assessments.

Status: In progress Target Completion Date: September 2024

Appendix F: Executive Director, National Center for Patient Safety Memorandum

Department of Veterans Affairs Memorandum

Date: August 9, 2023

From: Executive Director, National Center for Patient Safety (17PS)

Subj: OIG Draft Report, Review of Veterans Health Administration's Multi-Tiered Patient Safety Program (Project Number # 2022-02377-HI-1263) (VIEWS 10645444)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General draft report, Review of Veterans Health Administration's Multi-Tiered Patient Safety Program. The response to the recommendations made to the Executive Director, National Center for Patient Safety is in the memorandum from the Under Secretary for Health.

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:*)

Edward Yackel, DNP, FNP-C, FAANP

Executive Director, National Center for Patient Safety Response

VETERANS HEALTH ADMINISTRATION (VHA)
Action Plan
OIG Draft Report, Review of Veterans Health Administration's Multi-Tiered Patient Safety Program
(OIG 2022-02377-HI-1263)

Recommendation 2. The National Center for Patient Safety Executive Director evaluates the National Center for Patient Safety quarterly reports, includes an analysis of patient safety data in the reports, and establishes a mechanism for National Center for Patient Safety, in conjunction with VISNs, to direct interventions to promote improvements when facility patient safety program requirements are not met or if deemed necessary to enhance patient safety programs.

VHA Comments: Concur. NCPS will evaluate its quarterly reports to identify areas for improvement in analysis of the patient safety data. NCPS will identify a mechanism, such as a trigger, threshold, or benchmark to direct interventions when patient safety program requirements constitute an actionable deficiency. NCPS will revise the content of its quarterly reports and develop a process to review measures and monitors on a recurring basis.

Status: In progress Target Completion Date: September 2024

Recommendation 5. The National Center for Patient Safety Executive Director develops a patient safety program staffing configuration for patient safety managers to include facility complexity and patient safety program requirements with recurring reassessment and revision based on requirement changes.

VHA Comments: Concur. NCPS will analyze patient safety program requirements and develop recommended staffing configurations based on facility complexity level and patient safety manager workload. NCPS will develop and disseminate staffing guidance and will build staffing assessments into the PSO annual program assessment of facilities.

Status: In progress Target Completion Date: September 2024

Recommendation 6. The National Center for Patient Safety Executive Director establishes staffing guidance for VISN patient safety programs to include facility complexity and workload from other assigned responsibilities to ensure prioritization of patient safety officer oversight and support of facility patient safety programs.

VHA Comments: Concur. NCPS will analyze PSO workload and other assigned responsibilities and develop a recommended staffing configuration to support a highly functioning VISN patient safety program that prioritizes PSO oversight and support of facility patient safety programs. NCPS will develop and disseminate staffing guidance for each VISN.

Status: In progress Target Completion Date: September 2024

Recommendation 7. The National Center for Patient Safety Executive Director establishes processes to evaluate factors contributing to patient safety managers and patient safety officers' burnout, including patient safety manager turnover, and implements actions as needed to address burnout.

VHA Comments: Concur. NCPS understands that employee burnout is a recognized risk across the healthcare industry that increased during the COVID-19 public health emergency. NCPS recently conducted an environmental scan of the patient safety workforce that included an assessment of workload, burnout, turnover, and morale. NCPS will create and implement an action plan to address the results of the environmental scan.

Status: In Progress Target Completion Date: March 2024

Recommendation 8. The National Center for Patient Safety Executive Director evaluates patient safety manager and patient safety officer training and implements standardized formalized training with requirements for newly appointed patient safety managers and newly appointed patient safety officers to include time frames and completion.

VHA Comments: Concur. NCPS recognizes the importance of standardized formalized training with requirements for newly appointed PSMs and PSOs and created an action plan to start addressing this need. NCPS will continue to implement, evaluate, and update its training plan to meet the needs of newly appointed patient safety professionals. NCPS will create and communicate a comprehensive training plan that includes minimum requirements for newly appointed PSMs and PSOs.

Status: In progress Target Completion Date: June 2024

Recommendation 9. The National Center for Patient Safety Executive Director establishes standardized continuing education requirements to meet the training needs for patient safety managers and patient safety officers.

VHA Comments: Concur. NCPS recognizes the need for standardized continuing education requirements to meet the training needs for PSMs and PSOs. NCPS created an action plan to start addressing training needs but its initial focus was on foundational training. Therefore, NCPS will incorporate continuing education into its training plan.

NCPS will create and communicate a comprehensive training plan that includes standardized continuing education requirements for PSMs and PSOs.

Status: In progress Target Completion Date: September 2024

Glossary

To go back, press "alt" and "left arrow" keys.

adverse event. Unexpected or untoward events directly associated with the medical care or services provided at VHA facilities. Examples include patient falls, administration of the wrong medication, or procedural error.[91]

aggregate review. A method of evaluating a group of similar events to determine common causes and correct minor issues before they lead to more serious events.[92]

burnout. A feeling of "exhaustion of physical or emotional strength or motivation usually as a result of prolonged stress or frustration."[93]

close call. An event that could have led to an adverse event but did not. An example would be a procedure that was almost performed on the wrong patient but was caught prior to the procedure. These events are opportunities to develop preventive actions.[94]

closed-ended. Question using a yes/no or choice from provided answers.[95]

competencies. Demonstration of sufficient knowledge or skill.[96]

electronic health record modernization. A VHA initiative to replace the current EHR with the same commercial EHR software that is used by the Department of Defense.[97]

environmental scan. An assessment process that reviews healthcare trends, research, and Veteran and employee feedback to develop visions, goals, and objectives.[98]

full-time equivalent. A metric that uses the total number of hours worked, instead of the number of employees, to describe staffing. A full-time employee counts as 1.0 FTE, while a part-time employee counts as a fraction of 1.0 FTE based on the average number of hours worked.[99]

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[91] VHA Handbook 1050.01; VHA Directive 1050.01. These two policies contain similar language related to the definitions above unless otherwise noted.

[92] VHA Handbook 1050.01; VHA Directive 1050.01.

[93] *Merriam-Webster.com Dictionary*, "burnout," accessed October 21, 2022, https://www.merriam-webster.com/dictionary/burnout.

[94] VHA Handbook 1050.01; VHA Directive 1050.01.

[95] "Data-Gathering and Empathy Skills," chap. 2 in *Smith's Patient Centered Interviewing*, *4e*, eds. Auguste H. Fortin VI et al., (McGraw Hill, 2018), https://accessmedicine.mhmedical.com/content.aspx?sectionid=193676059&bookid=2446#194189627.

[96] *Merriam-Webster.com Dictionary*, "competency," accessed October 21, 2022, https://www.merriam-webster.com/dictionary/competency.

[97] VHA, "Electronic Health Record Modernization."

[98]. VHA Directive 1075, *Strategic-Operational Planning Process*, July 27, 2020.

[99] Congressional Research Service, *Federal Workforce Statistics Sources: OPM and OMB*, R43590, updated June 28, 2022.

harm. An injury attributed to the medical management of the patient that extends the length of hospitalization or created a disability at the time of discharge and is not related to the patient's underlying disease process.[100]

healthcare failure mode and effect analysis. One type of proactive risk assessment.[101]

high reliability organization. An organization that experiences "fewer accidents or events of harm, despite operating in a complex, high-risk environment."[102]

infection prevention and control program. VA facility program which "supports efforts to prevent and/or reduce the transmission of infectious diseases."[103]

Joint Patient Safety Reporting System. An electronic patient safety event reporting system and database used by the VHA to capture real time incident data throughout the healthcare system.[104]

JPSR event. A report entered into the JPSR System by an individual to communicate patient safety risks and adverse events for further investigation.[105]

Just culture. "An atmosphere of trust in which people are encouraged (even rewarded) for providing essential safety-related information."[106]

Likert scale. Rating system used in questionnaires that uses a range of responses, such as strongly agree, agree, and strongly disagree.[107]

patient safety advisories. Issued by the Office of the Deputy Undersecretary for Health for Operations and Management in concert with NCPS for potential threats and provide facilities recommendations that must be implemented or equivalent safety measure.[108]

patient safety alerts. Issued by the Office of the Deputy Undersecretary for Health for Operations and Management in concert with NCPS for actual or potential threats that "require specific, mandatory, and timely action."[109]

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[100] Agency for Healthcare Research and Quality, *PSNet: Patient Safety Network*, "Adverse Events, Near Misses, and Errors," September 7, 2019, https://psnet.ahrq.gov/primer/adverse-events-near-misses-and-errors.

[101] VHA Handbook 1050.01.

[102] VHA "High Reliability Organization (HRO) Fact Sheet."

[103] VHA Directive 1131(5), Management of Infectious Diseases and Infection Prevention and Control Programs, November 7, 2017, amended June 4, 2021.

[104] VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance.

[105] VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance.

[106] "VHA High Reliability Organization (HRO) Glossary of Terms," May 2023.

[107] *Britannica.com*, "Likert scale," accessed October 26, 2022, https://www.britannica.com/topic/Likert-Scale.

[108] VHA Handbook 1050.01; VHA Directive 1050.01.

[109] VHA Handbook 1050.01; VHA Directive 1050.01.

patient safety analysis(es). Processes used to evaluate safety events which includes RCA, patient safety assessment tool, and proactive risk assessments.[110]

patient safety assessment tool. A tool that uses defined questions to assist facilities in identifying risks and patient safety concerns.[111]

patient safety event. An event that could have resulted or did result in harm to the patient. Patient safety events include adverse events, close calls, and sentinel events.[112]

patient safety event reporting. VHA requires that once aware, facility staff must inform the PSM of any patient safety event, even if the condition has not resulted in an adverse event, close call, or other unsafe condition. Staff may use the JPSR system to submit information regarding the event.[113]

patient safety indicators. Hospitals use information from potentially avoidable adverse events to identify opportunities for improvement. Most indicators relate to surgeries and procedures.[114]

patient safety manager. The facility coordinator and point of contact responsible for patient safety policies and activities, to include promotion of the culture of safety, implementation of safety systems and development, maintenance and operation of the facility patient safety program.[115]

patient safety officer. VISN staff member responsible for having oversight and implementation of the VHA Patient Safety Program, providing direction for the formulation and establishment of patient safety policies, programs and practices in collaboration with VISN leadership and facilities within the VISN.[116]

patient safety professional. Collaborates with leaders, facility staff, and others to promote a culture of safety which includes analyzing adverse events, providing patient safety education, and implementing patient safety initiatives.[117]

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[110] VHA Assistant Under Secretary for Health for Quality and Patient Safety, "Annual Minimum Requirements for Facilities to Perform Patient Safety Analyses"; VHA Directive 1050.01.

[111] NCPS, "Patient Safety Assessment Tool," accessed November 1, 2022, https://dvagov.sharepoint.com/sites/vhancps/SitePages/PSAT.aspx. (This site is not publicly accessible.)

[112] VHA Handbook 1050.01; VHA Directive 1050.01.

[113] VHA Handbook 1050.01; VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance.

[114] "Patient Safety Indicators Overview," Agency for Healthcare Research and Quality, accessed November 1, 2022, https://qualityindicators.ahrq.gov/measures/psi_resources.

[115] VHA, "Position Description: Patient Safety Manager–Health System Specialist GS-671-12."

[116] VHA, "Functional Statement: Patient Safety Officer Nurse IV."

[117] "Patient Safety Professional Course," Military Health System and Defense Health Agency, accessed November 2, 2022, https://health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Quality-And-Safety-of-Healthcare/Patient-Safety/Patient-Safety-Products-And-Services/PS-Prof.

proactive risk assessment. "A method of evaluating a product or process to identify systems vulnerabilities, and their associated corrective actions, before an adverse event occurs."[118]

product recalls. Removing products from use when they are defective or potentially harmful.[119]

risk management. A quality and safety program to identify opportunities to "prevent and mitigate harm from clinical malpractice."[120]

root cause analysis (RCA). A process to analyze basic or contributing factors that is associated with a respective patient safety incident. The analysis gets to the "what" and "why" an event occurred to identify where changes in processes might reduce risk.[121]

safe patient handling and mobility. VHA program that establishes the standards for to protect staff and patients from injury from patient handling and mobility.[122]

safety assessment code. A risk assessment scoring system for patient safety events "that evaluates the frequency and severity of the event to determine a score."[123]

sentinel event. A type of adverse event that is "unexpected occurrences involving death, serious physical or psychological injury, or risk thereof."[124]

SPOT. An internal VHA software system designed to guide and document RCA teams' progress through the RCA process.[125]

staffing methodology. A process to determine staffing requirements that is based on multiple variables such as patient care needs, performance metrics, and professional judgement.[126]

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[118] VHA Handbook 1050.01; VHA Directive 1050.01.

[119] VHA Directive 1068, Removal of Recalled Medical Products, Drugs, and Food from VA Medical Facilities, June 19, 2020.

[120] "Medical-Legal Risk Management," VHA Office of Quality and Patient Safety, accessed November 1, 2022, https://vaww.qps.med.va.gov/divisions/qm/mlrm/mlrmDefault.aspx. (This site is not publicly accessible.)

[121] VHA Handbook 1050.01; VHA Directive 1050.01. The two policies contain different language related to the definition. VHA Directive 1050.01 defines RCA as "a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls."

[122] VHA Directive 1611(1), *Safe Patient Handling and Mobility Program*, March 23, 2018, amended July 16, 2020.

[123] VHA National Center for Patient Safety Guidebook for JPSR Business Rules and Guidance.

[124] VHA Handbook 1050.01; VHA Directive 1050.01. The two policies contain different language related to the definition. VHA Directive 1050.01 defines a sentinel event as "any patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that results in death, permanent harm or severe temporary harm."

[125] VHA Handbook 1050.01.

[126] VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, January 18, 2023.

state veterans home. "A home, approved by VA, which a State has established primarily for the care of Veterans disabled by age, disease or otherwise, who by reason of such disability are incapable of earning a living."[127]

third-party administrators. "Companies that are contracted by VHA to create a regional network of providers that provide care to Veterans."[128]

[127] VHA Directive 1145.01, *Survey Requirements for State Veterans Homes*, February 18, 2021.

[128] Veterans' Health Administration Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook, February 2022.

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