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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center in Chicago, Illinois

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Figure 1. *Jesse Brown VA Medical Center in Chicago, Illinois.*
Source: https://dvagov.sharepoint.com/sites/vhachs (accessed October 31, 2023).
(This website is not publicly accessible.)

Abbreviations

ADPCS	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
FY	fiscal year
LIP	licensed independent practitioner
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) report provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Jesse Brown VA Medical Center, which includes multiple outpatient clinics in Illinois and Indiana. The inspection covers key clinical and administrative processes that are associated with promoting quality care.

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

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

The OIG initiated an unannounced inspection of the Jesse Brown VA Medical Center during the week of June 5, 2023. The OIG held interviews and reviewed clinical and administrative processes related to specific areas of focus that affect patient outcomes. Although the OIG reviewed a broad spectrum of processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of the medical center's performance within the identified focus areas at the time of the OIG inspection and may help leaders identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results Summary

The OIG noted opportunities for improvement and issued eight recommendations to the Director, Chief of Staff, and Associate Director in the following areas of review: Quality, Safety, and Value; Environment of Care; and Mental Health. The number of recommendations should not be used as a gauge for the overall quality of care provided at this medical center. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care moving forward. Recommendations are based on retrospective findings of deficiencies in adherence to Veterans Health Administration national policy and require action plans that can effectively address systems issues that may have contributed to the deficiencies or interfered

with the delivery of quality health care. The results are detailed throughout the report, and the recommendations are summarized in appendix A on page 23.

VA Comments

The Veterans Integrated Service Network Director and Acting Medical Center Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 25–26, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendations 1, 3, 4, and 7 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to conduct routine oversight of VA medical facilities that provide healthcare services to veterans. This report's evaluation of the quality of care delivered in the inpatient and outpatient settings of the Jesse Brown VA Medical Center examines a broad range of key clinical and administrative processes associated with positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and medical center leaders so they can make informed decisions to improve care.[1]

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting expectations for quality care delivery; and promoting a culture to sustain positive change.[2] Effective leadership has been cited as "among the most critical components that lead an organization to effective and successful outcomes."[3]

To examine risks to patients and the organization, the OIG focused on core processes in the following five areas of clinical and administrative operations:[4]

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

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

[2] Anam Parand et al., "The Role of Hospital Managers in Quality and Patient Safety: A Systematic Review," *British Medical Journal* 4, no. 9 (September 5, 2014): 13, https://doi.org/10.1136/bmjopen-2014-005055.

[3] Danae F. Sfantou et al., "Importance of Leadership Style towards Quality of Care Measures in Healthcare Settings: A Systematic Review," *Healthcare (Basel)* 5, no. 4 (October 14, 2017): 73, https://doi.org/10.3390/healthcare5040073.

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

Methodology

The Jesse Brown VA Medical Center includes multiple outpatient clinics in Illinois and Indiana. General information about the medical center can be found in appendix B.

The inspection team conducted an on-site review the week of June 5, 2023.[5] During the site visit, the OIG did not receive any complaints beyond the scope of this inspection that required referral to the OIG hotline.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[6] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

This report's recommendations for improvement address problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until medical center leaders complete corrective actions. The Acting Medical Center Director's responses to the report recommendations appear within each topic area. The OIG accepted the action plans that leaders developed based on the reasons for noncompliance.

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

[5] The OIG's last comprehensive healthcare inspection of the Jesse Brown VA Medical Center occurred in January 2020. The Joint Commission completed hospital, behavioral health care and human services, and home care accreditation reviews in June 2021.

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

Results and Recommendations

Leadership and Organizational Risks

Healthcare leaders must focus their efforts to achieve results for the populations they serve.[7] High-impact leaders should be person-centered and transparent, engage front-line staff members, have a "relentless focus" on their organization's vision and strategy, and "practice systems thinking and collaboration across boundaries."[8] When leaders fully engage and inspire employees, create psychological safety, develop trust, and apply organizational values to all decisions, they lay the foundation for a culture and system focused on clinical and patient safety.[9]

To assess this medical center's leadership and risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Budget and operations
3. Employee satisfaction
4. Patient experience
5. Identified factors related to possible lapses in care and medical center leaders' responses

Executive Leadership Position Stability and Engagement

Each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves. The medical center had a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director, and Assistant Director. The Chief of Staff and ADPCS oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, the director, chief of staff, associate director, and assistant director positions had staff permanently assigned for over two years. According to a staff member, the permanently assigned Associate Director was detailed to another position, and the Assistant Director had been covering in an acting capacity since April 23, 2023. The acting ADPCS had been in the role for one month.

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

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

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

To help assess executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, acting ADPCS, acting Associate Director, and acting Assistant Director regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the medical center's fiscal year (FY) 2022 annual medical care budget of $710,102,346 had increased by over 7 percent compared to the previous year's budget of $659,283,690.[10] The Director reported spending the extra funds to increase the medical center's staffing from approximately 2,600 to 3,200 employees, including new specialty care providers such as a headache specialist and sleep disorder neurologist. The acting ADPCS and acting Associate Director highlighted using funds to replace outdated equipment such as scales, printers, and refrigerators. The Director indicated the current budget was not sufficient to support the current mission.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[11] Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on medical facility leaders.

To assess employee viewpoints, the OIG reviewed results from VA's All Employee Survey from FYs 2020 through 2022 regarding their perceived ability to disclose a suspected violation without fear of reprisal.[12] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the medical center over time.

Despite the medical center's result being lower than the VHA average in FY 2020, scores trended upward. The executive leadership team highlighted open communication between staff and leaders, regularly scheduled visits to employee workspaces, and the creation of a division focused on improving employee experiences. The acting ADPCS added that the increasing score reflected staff's greater trust in leaders.

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

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

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

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

All Employee Survey Group	FY 2020	FY 2021	FY 2022
VHA	3.8	3.9	3.9
Jesse Brown VA Medical Center	3.7	3.9	3.9

Source: VA All Employee Survey (accessed December 7, 2022).

Note: Respondents scored this survey item from 1 (Strongly disagree) through 6 (Do not know).

Patient Experience

VHA uses surveys from the Consumer Assessment of Healthcare Providers and Systems program to assess patients' healthcare experiences and compare them to the private sector. VHA also collects Survey of Healthcare Experiences of Patients data from Inpatient, Patient-Centered Medical Home (primary care), and Specialty Care surveys.[13] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the medical center from FYs 2020 through 2022. Table 2 provides survey results for VHA and the medical center over time.

There was an overall increase in patient satisfaction in the inpatient setting but decreases for primary and specialty care. The acting Associate Director reported holding a strategic retreat focused on leaders identifying new methods to improve patient satisfaction; during the retreat, they concentrated on patient survey comments to develop new initiatives. For example, the acting ADPCS stated leaders planned to implement the Commit to Sit initiative and had hired additional staff to work with patients and families to improve the discharge process.[14] The Director and Chief of Staff attributed the medical center's relatively high primary care scores to strong leaders in the community-based outpatient clinics and nurse managers knowing their patients well. The Director and Chief of Staff stated the survey included multiple specialties, each with unique characteristics, making it difficult to interpret the data and make improvements in specialty care.

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

[14] The Commit to Sit initiative is a commitment for nurses to find time to sit down with each patient, provide the patient their undivided attention, and develop a relationship built on trust and respect. Cari D. Lidgett, "Improving the Patient Experience through a Commit to Sit Service Excellence Initiative," *Patient Experience Journal* 3, no. 2 (Fall 2016): 67-72, https://pxjournal.org/cgi/viewcontent.cgi?article=1148&context=journal.

Table 2. Survey of Healthcare Experiences of Patients (FYs 2020 through 2022)

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Medical Center	VHA	Medical Center	VHA	Medical Center
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	57.8	69.7	64.9	68.9	62.8
Patient-Centered Medical Home: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	82.5	84.6	81.9	87.0	81.7	82.6
Specialty Care: *Overall, how satisfied are you with the health care you have received at your VA facility during the last 6 months?*†	84.8	87.0	83.3	82.3	83.1	82.8

Source: VHA Office of Quality and Patient Safety, Analytics and Performance Integration, Performance Measurement (accessed December 8 and 14, 2022).

**The response average is the percent of "Definitely yes" responses.*
†*The response average is the percent of "Very satisfied" and "Satisfied" responses.*

Identified Factors Related to Possible Lapses in Care and Medical Center Leaders' Responses

Leaders must ensure patients receive high-quality health care that is safe, effective, timely, and patient-centered because any preventable harm episode is one too many.[15] According to The Joint Commission's standards for leadership, a culture of safety and continual process improvements lead to safe, quality care for patients.[16] A VA medical facility's culture of safety and learning enables leaders to identify and correct systems issues. If leaders do not respond

[15] Frankel et al., *A Framework for Safe, Reliable, and Effective Care*; "Quality and Patient Safety (QPS)," Department of Veterans Affairs, accessed October 13, 2021, https://www.va.gov/QUALITYANDPATIENTSAFETY/.

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

when adverse events occur, they may miss opportunities to learn and improve from those events and risk losing trust from patients and staff.[17]

"A sentinel event is a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm)."[18] Additionally, an institutional disclosure is "a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."[19] Lastly, a large-scale disclosure is "a formal process by which VHA officials assist with coordinating the notification to multiple patients, or their personal representatives, that they may have been affected by an adverse event resulting from a systems issue."[20] To this end, VHA implemented standardized processes to guide leaders in measuring, assessing, and reacting to possible lapses in care to improve patient safety.[21]

The OIG requested a list of sentinel events and institutional disclosures that occurred during FY 2022 and reviewed the information staff provided. The Risk Manager stated patient safety staff or the Risk Manager identify events, and patient safety staff, in collaboration with the Chief of Staff, determine whether they are sentinel events. The Risk Manager also reported using VHA policy to determine whether an institutional disclosure is required, but the Chief of Staff makes the final decision. For institutional disclosures, the Risk Manager further discussed notifying the patient, family, or both, adding that the Chief of Staff completes the appropriate template in the electronic health record.

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

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

[18] The Joint Commission, *Comprehensive Accreditation Manual for Hospitals*, Sentinel Event Policy (SE), July 2023. VHA incorporates The Joint Commission's definition of a sentinel event in VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

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

[20] VHA Directive 1004.08.

[21] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (VHA rescinded and replaced this handbook with VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024. The new directive contains similar language regarding patient safety as the rescinded handbook.)

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[22] To achieve this goal, VHA requires that its medical facility leaders implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[23] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[24]

VHA implemented the National Center for Patient Safety program to develop a range of patient safety methodologies and practices. VHA's Patient Safety program includes staff assessing system vulnerabilities that may result in patient harm, reporting adverse patient safety events, and focusing on prevention.[25] According to The Joint Commission's standards for performance improvement, staff must analyze data to monitor performance and identify trends and improvement opportunities, then implement actions to enhance patient safety.[26]

The OIG assessed the medical center's processes for conducting peer reviews of clinical care.[27] Peer reviews, "when conducted systematically and credibly," reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and "long-term improvements in patient care."[28] Peer reviews are "intended to promote confidential and non-punitive assessments of care" that consistently contribute to quality management efforts at the individual provider level.[29]

The OIG team interviewed key managers and staff, evaluated peer reviews and patient safety reports, and reviewed four unanticipated deaths that occurred within 24 hours of inpatient admission during FY 2022.

Quality, Safety, and Value Findings and Recommendations

VHA requires the peer review committee to recommend "non-punitive, non-disciplinary actions to improve the quality of health care delivered" for all final peer reviews.[30] The OIG found the Peer Review Committee did not recommend improvement actions for final Level 3 peer

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

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

[24] VHA Directive 1100.16.

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

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

[27] A peer review is a "critical review of care performed by a peer," to evaluate care provided by a clinician for a specific episode of care, identify learning opportunities for improvement, provide confidential communication of the results back to the clinician, and identify potential system or process improvements. VHA Directive 1190.

[28] VHA Directive 1190.

[29] VHA Directive 1190.

[30] VHA Directive 1190.

reviews.[31] When the Peer Review Committee does not recommend corrective actions, providers may be unaware of changes needed to improve patient care practices and quality of care. The Risk Manager reported that Peer Review Committee leaders believed their letters notifying the providers' service chiefs of the Level 3 assignment met the directive's intent.

Recommendation 1

1. The Chief of Staff ensures the Peer Review Committee recommends improvement actions for all peer reviews.[32]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Chief of Staff reviewed this recommendation and found no other reason for non-compliance. The Risk Manager revised the Peer Review Final Level Notification memo template to include a statement with recommendations for improvement for all Level 3 Peer Reviews. Each memo is reviewed and signed by the Chief of Staff before issuing to the clinician to ensure compliance. Compliance is being monitored monthly with a target rate of at least 90% for six consecutive months. Jesse Brown VA (JBVA) Peer Review committee has been 100% compliant with including non-punitive recommendations for improvement in the Peer Review Final Level 3 Notification memo to the clinician for nine consecutive months (June 2023 through February 2024.) The facility requests closure of this recommendation.

[31] A Level 3 peer review is the "level at which most experienced and competent clinicians would have managed the case differently." VHA Directive 1190.

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

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of "all health care professionals who are permitted by law and the facility to practice independently."[33] These healthcare professionals are known as licensed independent practitioners (LIPs) and provide care "without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges."[34]

Privileges need to be specific and based on the individual practitioner's clinical competence. Privileges are requested by the LIP and reviewed by the responsible service chief, who then makes a recommendation to approve, deny, or amend the request. An executive committee of the medical staff evaluates the LIP's credentials and service chief's recommendation to determine whether "clinical competence is adequately demonstrated to support the granting of the requested privileges," and submits the final recommendation to the facility director.[35] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[36]

VHA states the Focused Professional Practice Evaluation is a defined period during which service chiefs assess LIPs' professional performance. The Focused Professional Practice Evaluation process occurs when an LIP is hired at the facility and granted initial or additional privileges. Facility leaders must also monitor the LIP's performance by regularly conducting an Ongoing Professional Practice Evaluation to ensure the continuous delivery of quality care.[37]

VHA's credentialing process involves the assessment and verification of healthcare practitioners' qualifications to provide care and is the first step in ensuring patient safety.[38] Historically, many VHA facilities had portions of their credentialing processes aligned under different leaders, which led to inconsistent program oversight, position descriptions, and reporting structures. VHA implemented credentialing and privileging modernization efforts to increase standardization and now requires all credentialing and privileging functions to be merged into one office under the chief of staff. VHA also requires facilities to have credentialing and

[33] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (VHA rescinded and replaced this handbook with VHA Directive 1100.21(1), *Privileging*, March 2, 2023, amended April 26, 2023. VHA previously replaced the credentialing portion of this handbook with VHA Directive 1100.20, *Credentialing of Health Care Providers*, September 15, 2021.)

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[39]

The OIG interviewed key managers and selected and reviewed the privileging folders of 28 medical staff members who underwent initial privileging or reprivileging during FY 2022.

Medical Staff Privileging Findings and Recommendations

The OIG made no recommendations.

[39] Assistant Under Secretary for Health for Operations/Chief Human Capital Management memo, "Credentialing and Privileging Staffing Modernization Efforts—Required Modernization Actions and Implementation of Approved Positions Fiscal Year 2020," December 16, 2020.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires staff to conduct environment of care inspections and track issues until they are resolved. The goal of VHA's environment of care program is to ensure "a safe, clean health care environment that provides the highest standards in the health care setting."[40] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[41]

The purpose of this inspection was to determine whether staff at VA medical facilities maintained a clean and safe healthcare environment in accordance with applicable standards. The OIG inspected selected areas that are often associated with higher risks of harm to patients. These areas may include inpatient mental health units, where patients with active suicidal ideations or attempts are treated, and community living centers, where vulnerable populations reside in a home-like environment and receive assistance in achieving their highest level of function and well-being.[42]

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

- Community Living Center (6W)
- Emergency Department
- Intensive Care Unit (4W)
- Medical/Surgical Inpatient Unit (5E)
- Mental Health Inpatient Unit (7W)
- Primary Care Clinic
- Women's Health Clinic

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

[41] VHA Directive 1608. The supply chain management system must meet the needs of its customers, which involves ensuring availability of the right product in the right place and at the right time. VHA Directive 1761, *Supply Chain Management Operations*, December 30, 2020.

[42] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (VHA rescinded and replaced this handbook with VHA Directive 1160.06, *Inpatient Mental Health Services,* September 27, 2023.) VHA Handbook 1142.01, *Criteria and Standards for VA Community Living Centers (CLC)*, August 13, 2008. (VHA rescinded and replaced this handbook with VHA Directive 1142(1), *Standards for Community Living Centers*, October 5, 2023, amended January 29, 2024.)

Environment of Care Findings and Recommendations

VHA requires staff to conduct environment of care inspections at least "twice per fiscal year in all areas where patient care is delivered."[43] The OIG reviewed FY 2022 environment of care inspection records and found staff inspected some patient care areas only once.[44] Failure to inspect patient care areas as required could result in unsafe conditions going unnoticed. The Safety Manager stated staff did not reschedule the first inspection that was skipped due to the holidays in the first quarter of FY 2022, and leaders did not discover it until the end of the FY.

Recommendation 2

2. The Director ensures staff conduct environment of care inspections in patient care areas at least twice per fiscal year.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The Director has reviewed the recommendation and found no other reason for non-compliance. The Safety Manager reconciled all locations within Performance Logic identifying them as patient care or non-patient care areas. The Safety Manager is monitoring completion of scheduled environment of care (EOC) inspections monthly through Performance Logic and will review again bi-annually before the end of six months so if an area is missed, it can be scheduled within the bi-annual inspection period. A target compliance rate of 100% for bi-annual EOC inspections in all patient care was set by the EOC team. Completion of scheduled monthly EOC inspections is reported by the Safety Manager at the Safety & Health Leadership Council monthly. 100% compliance has been achieved for all patient care areas scheduled for the months of October 2023 through February 2024. Compliance will continue to be monitored by the Safety Manager to ensure all patient care areas receive two EOC inspections this fiscal year.

The Joint Commission requires hospital staff to maintain all medical equipment in accordance with manufacturers' recommendations. If staff implement an alternative maintenance program, it must not reduce the safety of the equipment.[45] The OIG found staff did not perform the manufacturer's recommended annual preventive maintenance on the cardiac monitors in the

[43] VHA Directive 1608.

[44] The OIG found staff did not inspect the following patient care areas twice in FY 2022: Ambulatory Care Fast Trac (urgent care clinic), nursing primary care clinics, and Urology Clinic.

[45] The Joint Commission, *Standards Manual*, E-dition, EC.02.04.01, January 1, 2022.

Intensive Care Unit.[46] Neglecting preventive maintenance on this equipment may lead to malfunction, resulting in patient harm or death. The Chief of Biomedical Engineering reported believing biomedical engineering staff met requirements using an alternative maintenance program but said that in May 2023, they reinstituted the manufacturer's recommended preventive maintenance for the cardiac monitors. However, at the time of the OIG visit, staff had not performed the preventive maintenance.

Recommendation 3

3. The Associate Director ensures staff maintain all medical equipment in accordance with manufacturers' recommendations or use an alternative maintenance program that does not reduce the safety of the equipment.[47]

[46] Cardiac monitors or modules are removeable equipment used to connect patient-monitoring devices and send data signals to the monitor. "Planned maintenance should be carried out annually. Failure to implement the recommended maintenance schedule may cause equipment failure and possible health hazards." General Electric Company, *GE Carescape Monitor B850 Technical Manual*, September 19, 2016.

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

Medical center concurred.

Target date for completion: Completed

Medical center response: The Executive Leadership Team reviewed the recommendation and found no other reason for non-compliance. In July 2023, Jesse Brown VA (JBVA) Biomedical Engineering Chief collaborated with the VISN Health Care Technology Manager Engineering Lead in completing a comprehensive review of the entire JBVA medical equipment inventory and original equipment manufacturer (OEM) procedure and specifications to place all devices on OEM recommendation for preventive maintenance (PM) schedules. The use of alternative equipment maintenance (AEM) program was discontinued. By switching from an AEM to OEM program, it ensures every device is assigned the manufacturers intended PM frequency and the procedures followed are comprehensive. Switching preventive maintenance schedules to align with OEM recommendations has increased the total scheduled annual preventative maintenance requirements from 1,546 in FY21 to 3,726 in April 2024-March 2025. All medical devices and completion of PM is now documented in the Automated Equipment Management System/Medical Equipment Reporting System (AEMS/MERS) to improve ability to track equipment and PM compliance. The Chief of Biomedical Engineering Service is monitoring the compliance rate of timely PM completion monthly; "timely PM completion" is defined as completion of PM as scheduled per OEM frequency recommendations within +/- 30 days of the scheduled month. The numerator is the total number of medical devices that have their PM completed as scheduled within +/- 30 days of the scheduled month and the denominator is the total number of all medical devices that require PM. Compliance is reported to the Safety and Health Leadership Council. The target rate for compliance is 90% for six consecutive months. The monthly compliance rate has been met from August 2023 through January 2024. The facility requests closure of this recommendation.

VHA requires that "access to medications must be limited to those individuals approved by the VA medical facility."[48] The OIG found that three pneumatic tube stations used to transport medications had unrestricted access, allowing staff and unapproved users to access medications.[49] Unauthorized access to medications can lead to inappropriate use and cause harm. The Deputy Chief of Quality Safety Value stated nursing staff were supposed to wait at the pneumatic tube stations to receive medications and prevent unauthorized access; however, they did not consistently follow this process.

[48] VHA Directive 1108.07, *General Pharmacy Service Requirements*, November 28, 2022. (This directive was in effect at the time of the inspection. VHA amended it October 4, 2023.)

[49] The OIG observed the three unrestricted pneumatic tube stations in the Intensive Care Unit (4W), Medical/Surgical Inpatient Unit (5E), and Community Living Center (6W).

Recommendation 4

4. The Chief of Staff ensures medications transported by the pneumatic tube system are only accessible by approved individuals.[50]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Associate Director of Patient Care Services and the Chief of Staff reviewed the recommendation and found no other reason for non-compliance. Nursing Service worked with Engineering service to install plexiglass doors with keypad access for all the pneumatic tube systems on the inpatient units to secure medications. This project was completed on October 27, 2023. Only nursing staff assigned to specific areas who are authorized to handle medications have access to the pneumatic tube system. The facility requests closure of this recommendation.

VHA requires areas used by patients to be clean and orderly.[51] In patient rooms located in the Mental Health Inpatient Unit (7W), the OIG found that storage areas for patients' personal belongings were stained and could not be thoroughly cleaned. Inadequate cleaning can lead to the spread of pathogens such as bacteria and mold to patients and staff. The Deputy Chief Engineer indicated awareness of the issue, but stated leaders had not approved a project to replace these storage areas.

Recommendation 5

5. The Associate Director ensures Environmental Management Services staff keep areas used by patients clean and orderly.

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

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

Medical center concurred.

Target date for completion: August 31, 2025

Medical center response: The Associate Director reviewed the recommendation and found no other reason for non-compliance. Engineering Service has evaluated the shelving units in patient rooms on the acute psychiatric unit. A project for cleanable shelves has been submitted and due to the Non-Recurring Maintenance (NRM) program budget constraints from VA Central Office (VACO), the project will be funded in fiscal year 2025. If funding from VA central office becomes available as planned on/around January 15, 2025, then the Chief of Engineering maintains an estimated completion date of August 31, 2025 for this project.

VHA requires staff to check over-the-door alarms in mental health inpatient units with corridor doors to patient sleeping rooms according to manufacturers' guidelines to ensure proper functioning.[52] Staff told the OIG they did not check over-the-door alarms weekly, as recommended. If staff do not check over-the-door alarms in accordance with the manufacturer's guidelines, they may fail to alert when patients are in immediate danger. The Deputy Chief of Quality Safety Value stated the Quality Safety Value Chief and mental health leaders became aware of the manufacturer's recommendations for weekly testing in February 2023; however, after consultation with staff at other facilities, leaders continued monthly testing.

Recommendation 6

6. The Director ensures staff check over-the-door alarms in mental health inpatient units with corridor doors to patient sleeping rooms according to the manufacturer's guidelines.

[52] VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017; VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist," October 18, 2022.

Medical center concurred.

Target date for completion: September 30, 2024

Medical center response: The Director reviewed the recommendation and found no other reason for non-compliance. The manufacturer of the over-the-door alarm recommends conducting weekly "walk and press" testing by facility personnel. The manufacturer provided training to the mental health inpatient unit staff and the biomedical service technicians. The Nurse Manager of Inpatient Psychiatry will monitor compliance monthly with a target of 90% compliance rate for six consecutive months. The numerator is defined as the number of over-the-door alarms that are tested and pass; the denominator is defined as the number of doors with over-the-door alarms. Compliance will be reported by the Nurse Manager of Inpatient Psychiatry to the Nurse Executive Leadership Council.

VHA requires entrances into mental health inpatient units to include a sally port.[53] The OIG observed the entrance into the mental health inpatient units did not have a sally port. When the entrance does not have a sally port, there is a risk of patients leaving without authorization. The Director, Mental Health Service Line reported telling leaders about this vulnerability and initiating a project to create a sally port, planned for completion in September 2023.

Recommendation 7

7. The Director ensures all entrances into mental health inpatient units have a sally port.[54]

Medical center concurred.

Target date for completion: Completed

Medical center response: The Executive Leadership team reviewed this recommendation and found no other reason for non-compliance. Construction for the installation of a sally port began November 1, 2023. The project was completed and was operational as of December 22, 2023. The facility recommends closure of this recommendation.

[53] VHA Directive 1167. "The Sally Port is the space between two locked doors...[T]he first door is unlocked to enter the Sally Port and the second door remains closed and locked…[W]hen the first door is closed and locked, the second door opening to the unit is opened." VHA National Center for Patient Safety, "Mental Health Environment of Care Checklist."

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

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[55] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[56] The suicide rate for veterans was higher than for nonveteran adults during 2020.[57] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[58]

Due to the prevalence of suicide among at-risk veterans, VHA implemented a two-phase process to screen and assess for suicide risk in clinical settings. The phases include the Columbia-Suicide Severity Rating Scale Screener and subsequent completion of the Comprehensive Suicide Risk Evaluation when the screen is positive.[59] VHA states that providers should complete the Comprehensive Suicide Risk Evaluation on the same calendar day as the positive screen and notify the suicide prevention team if a patient reports suicidal behaviors during the evaluation.[60]

VHA requires each medical center and very large community-based outpatient clinic to have a full-time suicide prevention coordinator to track and follow up with high-risk veterans, conduct community outreach activities, and inform leaders of suicide-related events.[61]

To determine whether staff complied with selected suicide prevention requirements, the OIG interviewed key employees and reviewed relevant documents and the electronic health records of 50 randomly selected patients who had a positive suicide screen in FY 2022 and received primary care services.

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

[56] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed January 20, 2023.

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

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

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

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

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

Mental Health Findings and Recommendations

VHA states that providers should complete the Comprehensive Suicide Risk Evaluation the same day as a positive suicide risk screen in ambulatory care settings.[62] The OIG estimated that providers did not complete the Comprehensive Suicide Risk Evaluation for 26 (95% CI: 14 to 38) percent of patients following a positive screen, and for patients with completed evaluations, providers did not complete 49 (95% CI: 32 to 65) percent on the same day, both of which are statistically significantly above the OIG's 10 percent deficiency benchmark.[63] Failure to promptly evaluate patients could result in missed opportunities for providers to identify those who are at imminent risk for suicide and intervene. The Associate Chief of Staff, Ambulatory Care; Section Chief, Primary Care; and Chief, Medicine stated that primary care providers believed they met requirements for timely evaluation by discussing suicide risk during patient visits. Additionally, these leaders, along with the Director, Mental Health Service Line; Suicide Prevention Program Coordinator; and Program Manager, Primary Care/Mental Health Integration said suicide prevention program staff identified patients who did not have evaluations in their electronic health records and notified providers of the need to complete the evaluations, resulting in late documentation.

Recommendation 8

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

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

[63] A confidence interval (CI) is a range of estimates, computed based on a statistical sample, for an unknown true value. The 95% confidence level indicates that among confidence intervals computed from all possible samples with the same sample size and the study design, the true value would have been covered by the confidence intervals 95 percent of the time.

Medical center concurred.

Target date for completion: April 30, 2024

Medical center response: The Director reviewed the recommendation and found no other reason for non-compliance. The Primary Care clinics, in collaboration with Primary Care – Mental Health Integration (PC-MHI) and the Suicide Prevention teams implemented several actions to help identify Veterans who are at risk for suicide and complete the Comprehensive Suicide Risk Evaluation (CSRE) the same day a positive suicide screen is identified. These actions included multiple educational campaigns for Patient Aligned Care Team (PACT) staff (Providers, Nursing staff, PharmD) regarding mandatory completion of CSRE on the same day of a positive Columbia Suicide Severity Rating Scale (C-SSRS), educational sessions for primary care providers to ensure competence in completing CSREs, ongoing reminders during huddles to stress importance of communicating positive screens to the providers immediately, establishing a warm handoff process between the nurse and PC-MHI team and/or provider upon completion of a positive screen, providing clear communication to the PC-MHI provider regarding the need for a CSRE so that it is completed timely, review of fallouts and one-on-one education with respective clinicians reinforcing expectations, reinforcing warm handoff process between the nurse and PC-MHI team and/or provider upon completion of a positive screen, providing clear communication to the PC-MHI provider regarding the need for a CSRE so that it is completed timely, review of fallouts and one-on-one education with respective clinicians reinforcing expectations, reinforcing warm handoff between nurse and emergency department staff with clear communication of positive screens and the need for CSRE when indicated. As of February 19, 2024, the Suicide Prevention Team, with assistance from the Deputy Director of Mental Health, developed a pop-up notification box in the computerized patient record system (CPRS) to identify real-time positive C-SSRS screens that do not have a CSRE completed yet. This new feature is assigned to all Suicide Prevention Coordinators (SPC) and the Deputy Director of Mental Health. Anytime any patient's record is accessed, a pop-up appears with information on the number of positive C-SSRS. This prompts the SPC to look in VistA to identify the name/s of the Veteran/s with positive C-SSRS. Once the Veteran/s is/are identified, the SPC contacts the screening clinician to ensure the CSRE is completed the same day or within 24 hours of the positive screen for certain situations. The Suicide Prevention Team monitors the record throughout the day. They also provide support in completing CSREs as needed. The SPCs will monitor compliance and report results to the Executive Cabinet until 90% compliance has been achieved for six consecutive months. Compliance is defined as CSRE completion within the same calendar day, or 24 hours in certain instances, for positive C-SSRS in primary care clinics.

Report Conclusion

To assist leaders in evaluating the quality of care at their medical center, the OIG conducted a detailed inspection of five clinical and administrative areas and provided eight recommendations on systemic issues that may adversely affect patient care. The total number of recommendations does not necessarily reflect the overall quality of all services delivered within this medical center. However, the OIG's findings highlight areas of concern, and the recommendations are intended to help guide improvement efforts. The OIG appreciates the participation and cooperation of VHA staff during this inspection process. A summary of the recommendations is presented in appendix A.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The table below outlines eight OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Director, Chief of Staff, and Associate Director. The intent is for leaders to use recommendations as a road map to help improve operations and clinical care.

Table A.1. Summary Table of Recommendations

Review Areas	Recommendations for Improvement
Leadership and Organizational Risks	• None
Quality, Safety, and Value	• The Peer Review Committee recommends improvement actions for all peer reviews.
Medical Staff Privileging	• None
Environment of Care	• Staff conduct environment of care inspections in patient care areas at least twice per fiscal year. • Staff maintain all medical equipment in accordance with manufacturers' recommendations or use an alternative maintenance program that does not reduce the safety of the equipment. • Medications transported by the pneumatic tube system are only accessible by approved individuals. • Environmental Management Services staff keep areas used by patients clean and orderly. • Staff check over-the-door alarms in mental health inpatient units with corridor doors to patient sleeping rooms according to the manufacturer's guidelines. • All entrances into mental health inpatient units have a sally port.
Mental Health: Suicide Prevention Initiatives	• Providers complete the Comprehensive Suicide Risk Evaluation the same day as a patient's positive suicide risk screen in ambulatory care settings.

Appendix B: Medical Center Profile

The table below provides general background information for this high complexity (1b) affiliated medical center reporting to VISN 12.[1]

Table B.1. Profile for Jesse Brown VA Medical Center (537)
(October 1, 2019, through September 30, 2022)

Profile Element	Medical Center Data FY 2020*	Medical Center Data FY 2021†	Medical Center Data FY 2022‡
Total medical care budget	$601,687,273	$659,283,690	$710,102,346
Number of:			
• Unique patients	47,778	52,934	54,171
• Outpatient visits	553,104	618,861	594,532
• Unique employees§	2,284	2,401	2,423
Type and number of operating beds:			
• Community living center	22	22	22
• Domiciliary	19	12	11
• Medicine	158	158	158
Average daily census:			
• Community living center	13	14	11
• Domiciliary	19	12	11
• Medicine	91	98	94

Source: VHA Support Service Center and VA Corporate Data Warehouse.

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

**October 1, 2019, through September 30, 2020.*
†*October 1, 2020, through September 30, 2021.*
‡*October 1, 2021, through September 30, 2022.*
§*Unique employees involved in direct medical care (cost center 8200).*

[1] VHA medical facilities are classified according to a complexity model; a designation of "1b" indicates a facility with "medium-high volume, high risk patients, many complex clinical programs, and medium-large research and teaching programs." VHA Office of Productivity, Efficiency & Staffing (OPES), "VHA Facility Complexity Model Fact Sheet," October 1, 2020. An affiliated medical center is associated with a medical residency program. VHA Directive 1400.03, *Educational Relationships*, February 23, 2022.

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 12, 2024

From: Director, VA Great Lakes Health Care System (10N12)

Subj: Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center in Chicago, Illinois

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

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

1. I have reviewed the Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center in Chicago, Illinois.
2. I concur with the findings and recommendations proposed.
3. I concur with the submitted action plans from the facility.
4. I would like to thank the OIG Inspection team for a thorough review of the Jesse Brown VA Medical Center in Chicago, Illinois.

(Original signed by:)

Daniel S. Zomchek, Ph.D., FACHE
Network Director, VISN 12

Appendix D: Medical Center Director Comments

Department of Veterans Affairs Memorandum

Date: March 8, 2024

From: Acting Medical Center Director, Jesse Brown VA Medical Center (537)

Subj: Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center in Chicago, Illinois

To: Director, VA Great Lakes Health Care System (10N12)

1. Thank you for the opportunity to review and provide a response to the findings from the draft report, Comprehensive Healthcare Inspection of the Jesse Brown VA Medical Center in Chicago, Illinois.
2. I have reviewed and concur with the recommendations in the OIG draft report. I have provided actions completed after our Comprehensive Healthcare Inspection to correct these findings with supporting documentation. Therefore, we are requesting closure for facility recommendations 1, 3, 4, and 7.
3. I appreciate the Office of Inspector General's partnership in our continuous improvement efforts for our Veterans.

(Original signed by:)

Sarah Unterman for
Clifford A. Smith, PhD, ABPP
Acting Medical Center Director

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