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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection of the Central Virginia VA Health Care System in Richmond

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Figure 1. *Richmond VA Medical Center of the Central Virginia VA Health Care System.*

Source: https://www.va.gov/richmond-health-care/ (accessed February 13, 2024).

Abbreviations

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 Central Virginia VA Health Care System, which includes the Richmond VA Medical Center and multiple outpatient clinics in Virginia. 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 Central Virginia VA Health Care System during the week of July 31, 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 healthcare system'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 six recommendations to the Executive Director, Chief of Staff, and Associate Director in the following areas of review: Quality, Safety, and Value; Medical Staff Privileging; and Environment of Care. The number of recommendations should not be used as a gauge for the overall quality of care provided at this system. 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 Executive Director agreed with the comprehensive healthcare inspection findings and recommendations and provided acceptable improvement plans (see appendixes C and D, pages 26–27, and the responses within the body of the report for the full text of the directors' comments). The OIG considers recommendations 1 and 2 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

Contents

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 Central Virginia VA Health Care System 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 healthcare system 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 Central Virginia VA Health Care System includes the Richmond VA Medical Center and multiple outpatient clinics in Virginia. General information about the healthcare system can be found in appendix B.

The inspection team conducted an on-site review during the week of July 31, 2023.[5] 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 healthcare system leaders complete corrective actions. The Executive 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 medical center occurred in May 2021. The Joint Commission performed hospital, behavioral health care and human services, and home care accreditation reviews in October 2020.
[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 healthcare system'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 healthcare system 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 healthcare system had a leadership team consisting of the Executive Director (Director), Chief of Staff, Associate Director for Patient Care Services, Associate Director, Assistant Director/Chief Experience Officer, and Assistant Director/Health Care Center Administrator. The Chief of Staff and Associate Director for Patient Care Services oversaw patient care, which included managing service directors and program chiefs.

At the time of the OIG inspection, all members of the executive leadership team had been in their roles for at least one year. To help assess executive leaders' engagement, the OIG interviewed the Director, Chief of Staff, Associate Director for Patient Care Services, Associate Director, and

[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.

Assistant Director/Chief Experience Officer regarding their knowledge, involvement, and support of actions to improve or sustain performance.

Budget and Operations

The OIG noted that the healthcare system's fiscal year (FY) 2022 annual medical care budget of $954,602,251 had increased by almost 7 percent compared to the previous year's budget of $892,683,858.[10] The Director stated the current budget was sufficient, but it might be insufficient if all existing vacant positions were filled. The Associate Director reported using the increased funds to purchase equipment, including two magnetic resonance imaging machines and several vital sign monitors.[11] The Associate Director also said the healthcare system received additional special purpose funds for biomedical engineers, innovation, research, printers, additional parking lot lighting, and emergency cots.

Employee Satisfaction

The All Employee Survey is an "annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential."[12] 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.[13] Table 1 provides relevant survey results for Veterans Health Administration (VHA) and the healthcare system over time.

The healthcare system's survey scores were lower than VHA averages across all three years. However, the scores indicated employees' comfort disclosing suspected violations improved over time. The executive leadership team attributed the improvement, in part, to the creation of a forum to encourage patient safety reporting; a civility campaign; and a diversity advisory committee, which held diversity town halls, focus groups, and virtual training sessions, to improve the culture of acceptance.

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

[11] Magnetic resonance imaging is a noninvasive tool used to look at organs, tissue, and skeletal systems and to produce detailed computer-generated images of the body using magnetic fields. "MRI [magnetic resonance imaging]," Mayo Clinic, accessed November 6, 2019, https://www.mayoclinic.org/tests-procedures/mri/about/pac-20384768.

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

[13] 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
Central Virginia VA Health Care System	3.6	3.8	3.8

Source: VA All Employee Survey (accessed December 27, 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.[14] The OIG reviewed responses to three relevant survey questions that reflect patient experiences with the healthcare system from FYs 2020 through 2022. Table 2 provides survey results for VHA and the healthcare system over time.

Primary and specialty care survey scores for all three years were higher than VHA averages, indicating patients were generally more satisfied with their outpatient care than VHA patients overall. Inpatient scores, however, indicated patients were less satisfied. The Chief of Staff identified patients' perceptions of their inpatient room as a challenge because the facility was old, the rooms did not have bright colors, and the lights were dim, which can prevent surroundings from looking clean. The Chief of Staff described initiating a program with Environmental Management Services staff using scripted language to tell patients they were there to clean the room. The Director stated leaders reviewed scores on a weekly basis to identify trends and address issues; for example, staff updated the telephone directory and improved the infrastructure because of the survey.

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

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

Questions	FY 2020		FY 2021		FY 2022	
	VHA	Healthcare System	VHA	Healthcare System	VHA	Healthcare System
Inpatient: *Would you recommend this hospital to your friends and family?**	69.5	63.1	69.7	64.4	68.9	65.1
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	82.9	81.9	88.9	81.7	82.0
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	85.3	83.3	83.9	83.1	85.9

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 Healthcare System 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, July 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 Patient Safety Manager reported reviewing events entered in the Joint Patient Safety Reporting system to determine whether they should be classified as sentinel events.[22] The Patient Safety Manager added that patient safety staff conduct root cause analyses for sentinel events.[23] The Chief, Quality Management discussed reviewing patient safety events with the executive leadership team daily. When events require an institutional disclosure, the Risk Manager described notifying the Chief of Staff or Associate Director for Patient Care Services.

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[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.)

[22] VHA uses the Joint Patient Safety Report System for "data management on medical errors and close calls/near misses." "VHA National Center for Patient Safety Frequently Asked Questions," Department of Veterans Affairs, accessed December 21, 2022, https://www.patientsafety.va.gov/about/faqs.asp.

[23] "RCA [root cause analysis] is a comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls." VHA Directive 1050.01(1).

Leadership and Organizational Risks Findings and Recommendations

The OIG made no recommendations.

Quality, Safety, and Value

VHA is committed to providing exceptional health care to veterans.[24] 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.[25] Many quality-related activities are informed and required by VHA directives and nationally recognized accreditation standards.[26]

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.[27] 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.[28]

The OIG assessed the healthcare system's processes for conducting peer reviews of clinical care.[29] 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."[30] 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.[31]

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

Quality, Safety, and Value Findings and Recommendations

Following a peer review, VHA requires the peer review committee to recommend actions to improve health care quality, and supervisors to communicate the recommendations to providers

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

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

[26] VHA Directive 1100.16.

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

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

[29] 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.

[30] VHA Directive 1190.

[31] VHA Directive 1190.

for peer reviews assigned a Level 2 or 3 and ensure they implement appropriate actions.[32] The OIG evaluated seven Level 3 peer reviews and found two lacked evidence providers implemented the recommended improvement actions. When providers do not implement the recommended actions, patient care practices are unlikely to improve and may result in adverse patient outcomes. The Peer Review Coordinator reported sending a memorandum to applicable service chiefs outlining the Peer Review Committee's individual recommendations; however, service chiefs did not respond to requests for confirmation that providers implemented the recommended actions.

Recommendation 1

1. The Chief of Staff ensures supervisors communicate the Peer Review Committee's recommendations for all Level 3 peer reviews to providers and ensure they implement the improvement actions.[33]

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Peer Review Coordinator (PRC) refined the process of sending a memorandum to applicable service chiefs outlining the Peer Review Committee's individual recommendations and has been receiving the requested written confirmation response back from the service chiefs that the providers implemented the recommended actions. Evidence includes four level 3 letters over the last six months reflecting six consecutive months of compliance. Although the PRC preference is receiving a signed memo, an email confirmation is also accepted by the Service Chief, as both are evidenced below. Facility requests closure of this recommendation based on evidence provided.

[32] A Level 2 "is the level at which most experienced and competent clinicians might have managed the case differently but it remains within the standard of care." A Level 3 "is the level at which most experienced and competent clinicians would have managed the case differently." VHA Directive 1190.

[33] The OIG reviewed evidence sufficient to demonstrate that leaders completed improvement actions and therefore closed the recommendation 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."[34] 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."[35]

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.[36] LIPs are granted clinical privileges for a limited time and must be reprivileged prior to their expiration.[37]

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.[38]

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.[39] 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

[34] 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.)

[35] VHA Handbook 1100.19.

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] VHA Handbook 1100.19.

[39] VHA Directive 1100.20.

privileging managers and specialists with job duties that align under standard position descriptions.[40]

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

VHA requires an executive committee of the medical staff (known as the Medical Executive Council at this healthcare system) to document its review of LIPs' professional practice evaluations and recommend privileges based on the results.[41] The OIG found the Medical Executive Council meeting minutes did not have documentation it recommended privileges based on professional practice evaluation results. Insufficient documentation of the council's privileging recommendations could adversely affect quality of care and patient safety. The Chief of Staff and Health System Specialist Supervisor stated the Medical Executive Council did not document some of its own recommendations to continue privileges due to a lack of oversight and because the Chief of Staff and Health System Specialist Supervisor, both responsible for writing and reviewing the council's minutes for accuracy, were on leave during the applicable meetings.

Recommendation 2

2. The Chief of Staff ensures the Medical Executive Council documents its review of licensed independent practitioners' professional practice evaluations and recommend privileges based on the results.[42]

[40] 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.

[41] VHA Handbook 1100.19; VHA Directive 1100.21(1).

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

Healthcare system concurred.

Target date for completion: Completed

Healthcare system response: The Chief of Staff and Health System Specialist Supervisor immediately revised the previous Medical Executive Council (MEC) reporting process. The new process requires the minutes to contain the following statement confirming that "All information was reviewed and agreed with the Medical Professional Standards Committee (MPSC) minutes approved by MEC and will be forwarded to the Director. All committee members were present or had a representative designee in attendance." Evidence includes the last six months of MEC minutes reflecting six consecutive months of compliance. Facility requests closure of this recommendation based on evidence provided.

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."[43] The environment of care program includes elements such as infection control, patient and employee safety, privacy, and supply chain management.[44]

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.[45]

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 (1N)
- Emergency Department
- Medical/surgical inpatient unit (4C)
- Mental health inpatient unit (1F)
- Primary Care Clinic
- Surgical intensive care unit (2G)
- Women's Health Clinic

[43] 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.)

[44] 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.

[45] 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 storage locations of reusable medical equipment to remain within acceptable temperature and humidity ranges.[46] The OIG found that humidity had not remained in the acceptable range in a clean storage area containing reusable medical equipment, and staff had not relocated the items. When medical equipment is not stored in the appropriate conditions, it may compromise the integrity of packaging, which could result in contamination or loss of efficacy. The Chief of Engineering stated the air handler had difficulty controlling humidity, adding that engineering department staff adjusted the air handler, which often resulted in improvements. However, the Chief of Engineering provided the OIG with environmental monitoring system reports that showed a steady humidity increase over the four months preceding the inspection. The Director reported planning to fund an air handler replacement project in FY 2024.

Recommendation 3

3. The Executive Director ensures staff store reusable medical equipment in temperature- and humidity-controlled storage locations.

[46] VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016. (VHA rescinded and replaced this directive with VHA Directive 1116, *Management of Critical and Semi-Critical Reusable Medical Devices*, July 17, 2023.)

Healthcare system concurred.

Target date for completion: December 31, 2026

Healthcare system response: The replacement of the Air Handler Unit (AHU) was requested for engineering design via the Strategic Capital Investment Planning (SCIP) process on July 7, 2023. The design contract has yet to be awarded and the award date is anticipated to occur in September 2024. Once the design is completed a construction contract will be solicited and subsequently awarded projected for December 2025, with completion in December 2026. In the meantime, a coil was replaced in one of the two units in January 2024, and the second is in process of being replaced now. Until the units are completely replaced, monitoring of temperatures and humidity levels via the environmental monitoring system will continue, and reusable medical equipment will be immediately relocated to appropriate areas as needed.

The Chief of Engineering will ensure temperature and humidity data will be reported at the Environment of Care Committee and to the Administrative Executive Committee monthly.

VHA requires staff to keep areas used by patients clean and safe.[47] Further, VHA requires staff to keep storerooms clean and uncluttered, with no visible dust or soil.[48] The OIG found the following deficiencies in patient care areas:

- Two areas had patient rooms that had not been cleaned[49]
- Three areas had dirty and stained floors[50]
- Three areas had dirty and dusty medication areas[51]
- Two areas had clean storage areas that were dirty and dusty[52]

Dirty patient rooms, medication areas, storage rooms, and floors may spread illness or pathogens, such as bacteria and mold, to patients and staff. The Chief of Environmental Management Services stated that due to the department's high turnover and number of new employees, staff needed more training to address details when cleaning after patient discharges and stripping and waxing floors. The Associate Director for Patient Care Services reported

[47] VHA Directive 1850, *Environmental Programs Service*, March 31, 2017. (VHA rescinded and replaced this directive with VHA Directive 1850, *Environmental Programs Service*, January 30, 2023.)

[48] VHA Directive 1761.

[49] The OIG found patient rooms had not been cleaned in the community living center and mental health inpatient unit.

[50] The OIG identified dirty and stained floors in the surgical intensive care unit, medical/surgical inpatient unit, and community living center.

[51] The OIG observed dirty and dusty medication areas in the mental health inpatient unit, surgical intensive care unit, and community living center.

[52] The OIG noted clean storage areas that were dirty and dusty in the Emergency Department and surgical intensive care unit.

staffing shortages had negatively affected nurses' ability to clean the medication rooms, and the Chief of Supply Chain Management Services said that in addition to high turnover, staff had insufficient time to clean the storage areas as frequently as needed.

Recommendation 4

4. The Associate Director ensures staff keep storage rooms and areas used by patients clean and safe.

Healthcare system concurred.

Target date for completion: May 31, 2024

Healthcare system response: Environmental Management Services (EMS) leaders are collaborating with clinical leaders to maintain safe and clean patient care areas. Concurrently, EMS staff have been retrained on EMS departmental policies and procedures. If services and repairs are needed, then unit managers will enter a work order to Engineering.

Second, EMS leadership has developed a specific team to focus on deep floor cleaning in all the patient areas. This team proactively addresses patient areas on a routine schedule. Departmental Housekeeping Supervisors conduct regular inspections of all the areas and provide reports using ES Optimizer. Monthly data is reported at the Environment of Care Committee and to the Administrative Executive Committee monthly.

Third, a discharge team was created to address all discharge cleaning needs, and retraining was provided to EMS staff. The Departmental Housekeeping Supervisors inspect random rooms immediately after discharge and terminal cleaning to validate effectiveness using adenosine triphosphate (ATP) monitors and other metrics. Furthermore, supervisors report to EMS leadership and the Environment of Care Committee and Administrative Executive Committee monthly.

All Monitoring will continue until 90% compliance is maintained for six consecutive months.

VHA states "access to medications must be limited to those individuals approved by the VA medical facility."[53] The OIG discovered three pneumatic tube stations used to transport medications from the pharmacy had unrestricted access, allowing staff and unapproved users to access medications. Additionally, the OIG found unsecured medications in one of the pneumatic tube stations.[54] Unauthorized access to medications can lead to inappropriate use and cause harm

[53] 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.)

[54] The OIG observed the three unrestricted pneumatic tube stations in the Emergency Department, surgical intensive care unit, and medical/surgical inpatient unit.

to patients or staff. The Associate Director stated staff were unaware that medications left in the pneumatic tube system were considered unsecured.

Recommendation 5

5. The Chief of Staff limits medication access to approved staff members.

Healthcare system concurred.

Target date for completion: November 1, 2024

Healthcare system response: While sending medications staff will utilize a Personal Identification Number (PIN) for the pneumatic tube system, and the receiving location will enter the PIN to release the medication from the pneumatic tube system. This process will secure all medications being transported, eliminating the potential of unauthorized access. Pharmacy will oversee the education and implementation in collaboration with Nursing and Engineering Services. The Chief of Pharmacy will ensure monitoring is reported monthly to the Environment of Care Committee and the Administrative Executive Committee on a monthly basis. Numerator will be the number of medication deliveries retrieved from the pneumatic tube system utilizing the PIN code. Denominator will be the total number of medication deliveries retrieved from the pneumatic tube system.

All monitoring will continue until 90% compliance is maintained for six consecutive months.

VHA requires feminine hygiene products to be available in toilet rooms within proximity to areas where pelvic examinations are performed, and in all women's, unisex, and family public restrooms at no cost.[55] The OIG found two public unisex restrooms, two public women's restrooms, and two restrooms in the women's clinic that did not have feminine products available. Providing essential supplies where needed improves patients' dignity and comfort. The Chief of Environmental Management Services said reasons for noncompliance included high turnover of department staff, recent conversion of some restrooms to unisex, and staff sometimes failing to follow training regarding provision of feminine hygiene products in restrooms.

Recommendation 6

6. The Associate Director ensures all toilet rooms within proximity to areas where pelvic examinations are performed, and all women's, unisex, and family public restrooms have feminine hygiene products available at no cost.

[55] VHA Directive 1330.01(7), *Health Care Services for Women Veterans*, February 15, 2017, amended May 14, 2023.

Healthcare system concurred.

Target date for completion: May 31, 2024

Healthcare system response: The Chief, Environmental Management Services (EMS), and EMS Housekeeping Supervisors will conduct regular inspections (no less than weekly) of all bathrooms where feminine hygiene products are required. Products will be replaced and/or replenished as needed.

Findings will be reported to EMS leadership regularly, and the Environment of Care Committee and Administrative Executive Committee monthly.

All Monitoring will continue until 90% compliance is maintained for six consecutive months.

Mental Health: Suicide Prevention Initiatives

Suicide prevention is the top clinical priority for VA.[56] Suicide is a significant health problem in the United States, with over 45,000 lives lost in 2020.[57] The suicide rate for veterans was higher than for nonveteran adults during 2020.[58] "Congress, VA, and stakeholders continue to express concern over seemingly limited progress made…to reduce veteran suicide."[59]

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.[60] 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.[61]

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.[62]

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

[57] "Suicide Prevention: Facts about Suicide," Centers for Disease Control and Prevention, accessed March 10, 2022.

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

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

[60] 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.)

[61] 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.)

[62] 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

The OIG made no recommendations.

Report Conclusion

To assist leaders in evaluating the quality of care at their healthcare system, the OIG conducted a detailed inspection of five clinical and administrative areas and provided six 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 healthcare system. 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 six OIG recommendations aimed at reducing vulnerabilities that may lead to adverse patient safety events. The recommendations are attributable to the Executive 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	• Supervisors communicate the Peer Review Committee's recommendations for all Level 3 peer reviews to providers and ensure they implement the improvement actions.
Medical Staff Privileging	• The Medical Executive Council documents its review of licensed independent practitioners' professional practice evaluations and recommend privileges based on the results.
Environment of Care	• Staff store reusable medical equipment in temperature- and humidity-controlled storage locations. • Staff keep storage rooms and areas used by patients clean and safe. • The Chief of Staff limits medication access to approved staff members. • Toilet rooms within proximity to areas where pelvic examinations are performed, and all women's, unisex, and family public restrooms have feminine hygiene products available at no cost.
Mental Health: Suicide Prevention Initiatives	• None

Appendix B: Healthcare System Profile

The table below provides general background information for this highest complexity (1a) affiliated healthcare system reporting to VISN 6.[1]

Table B.1. Profile for Central Virginia VA Health Care System (652) (October 1, 2019, through September 30, 2022)

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Total medical care budget	$943,808,539	$892,683,858	$954,602,251
Number of:			
• Unique patients	69,239	72,144	77,170
• Outpatient visits	732,102	831,791	819,618
• Unique employees§	3,393	3,340	3,313
Type and number of operating beds:			
• Community living center	98	98	98
• Domiciliary	16	16	16
• Medicine	80	80	80
• Mental health	22	22	22
• Rehabilitation medicine	42	42	42
• Spinal cord	100	80	80
• Surgery	44	44	44
Average daily census:			
• Community living center	33	20	21
• Domiciliary	7	6	8
• Medicine	37	38	32
• Mental health	14	12	14
• Rehabilitation medicine	22	23	21
• Spinal cord	37	28	26

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

Profile Element	Healthcare System Data FY 2020*	Healthcare System Data FY 2021†	Healthcare System Data FY 2022‡
Average daily census, cont.:			
• Surgery	17	18	20

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).*

Appendix C: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: March 12, 2024

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subj: Comprehensive Healthcare Inspection of the Central Virginia VA Health Care System in Richmond

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

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

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Central Virginia VA Health Care System in Richmond.
2. I have reviewed and concur with the OIG recommendations and the action plans submitted by the Central Virginia VA Health Care System. As we remain committed to ensuring our Veterans receive exceptional care, VISN 6 Leadership will ensure the actions to correct the findings are completed and sustained as described in their responses.

(Original signed by:)

James Goff for
Paul S. Crews, MPH, FACHE

Appendix D: Healthcare System Director Comments

Department of Veterans Affairs Memorandum

Date: March 7, 2024

From: Executive Director, Central Virginia VA Health Care System (652)

Subj: Comprehensive Healthcare Inspection of the Central Virginia VA Health Care System in Richmond

To: Director, VA Mid-Atlantic Health Care Network (10N6)

1. Thank you for the opportunity to review the draft report of the Comprehensive Healthcare Inspection of the Central Virginia VA Health Care System, Richmond, Virginia.
2. I have reviewed and concur with the recommendations. Moreover, as described in the responses, I will ensure the actions to correct the findings are completed and sustained.
3. I appreciated the opportunity to review the report as it assists with shaping our efforts to improve health care outcomes for our Veterans.

(Original signed by:)

J. RONALD JOHNSON, FACHE

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Angela Enlow, PhD, Team Leader Christine El-Zoghbi, PhD Megan Magee, MSN, RN Carol Manning, MSW, MPH Kara McDowell, BSN, RN Cheryl Walsh, MS, RN
Other Contributors	Melinda Alegria, AuD, CCC-A Limin Clegg, PhD Kaitlyn Delgadillo, BSPH Jennifer Frisch, MSN, RN Justin Hanlon, BAS LaFonda Henry, MSN, RN Cynthia Hickel, MSN, CRNA Amy McCarthy, JD Scott McGrath, BS Joan Redding, MA Larry Ross, Jr., MS Caitlin Sweany-Mendez, MPH Erika Terrazas, MS Elizabeth Whidden, MS, APRN Jarvis Yu, MS

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