Department of Veterans Affairs
Office of Inspector General

Audit of the Veterans Health Administration's Domiciliary Safety, Security, and Privacy

Report No. 08-01030-05

October 9, 2008

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Contents

Executive Summary

Introduction

The Office of Inspector General (OIG) conducted this audit to assess the effectiveness of safety, security, and privacy of veterans residing in VA domiciliaries. The audit objective was to determine if the safety, security, and privacy issues identified at Veterans Health Administration (VHA) domiciliaries we randomly selected for review were corrected.

The Domiciliary Residential Rehabilitation Treatment Program (DRRTP) is VA's oldest health care program. Domiciliary care was initially established to provide services to economically disadvantaged veterans, and it remains committed to serving that group. The domiciliary has evolved from a "soldiers' home" to become an active clinical rehabilitation and treatment program for veterans.

The mission of the DRRTP is to provide coordinated, integrated, rehabilitative, and restorative clinical care in a bed-based program. The goal of the DRRTP is to help eligible veterans achieve and maintain the highest level of functioning and independence possible. In 2005, DRRTP became fully integrated with other residential rehabilitation and treatment programs within the Office of Mental Health Services. As of June 2008, there were 49 domiciliaries in 28 states. VHA plans to open four additional domiciliaries by the end of fiscal year (FY) 2009.

Domiciliary residents normally face many challenges such as homelessness, substance abuse, and mental illness. Veteran safety issues within DRRTPs have recently come to the attention of the public and Congress. Members of Congress have also expressed concerns that VA domiciliary care programs meet the safety and capacity needs of women veterans. Female veterans represented approximately 4 percent of the total domiciliary population in FY 2007. As early as March 2006, VHA reported to the VA's Advisory Committee on Women Veterans that women veterans have experienced a lack of privacy in the DRRTPs. The report also noted that women veterans often felt intimidated in the predominantly male facilities and were concerned for their safety.

VHA Handbook 1162.02, "Domiciliary Residential Rehabilitation and Treatment Program," establishes procedures for the domiciliaries and requires the Chief, DRRTP to complete an Annual Narrative Report that includes an Annual Safety and Security Assessment (ASSA). The ASSA consists of 32 questions to be completed by the Chief, DRRTP and other medical center staff and is used as a planning tool to identify potential safety, security, and privacy issues. (For additional information on ASSA questions, see Appendix B). The handbook requires each domiciliary to identify any safety, security, and privacy concerns as part of the annual reporting requirements and includes an action plan with a timeline for remediation of problems. All 47 domiciliaries at the end of

FY 2007 completed an ASSA, and 44 (94 percent) reported that their facility had at least one safety or security issue.

In January 2008, the Deputy Under Secretary for Health for Operations and Management provided guidance and authorized funds for the immediate implementation of key card systems on the entryways and exits of perimeter doors and programmable key card systems and/or closed circuit monitoring systems of female bedroom doors at all Residential Rehabilitation Treatment Programs (RRTP) to improve safety and security. The Deputy Under Secretary cited this as a "national priority."

Management Oversight. The Director of RRTP is responsible for directing and overseeing the operation of the DRRTPs nationally. The Domiciliary Field Advisory Board (DFAB) works collaboratively with VHA Central Office program staff to implement recommendations related to the DRRTPs. They also monitor DRRTPs to ensure that the safety and security of residents and other DRRTP areas of concern are addressed, such as the quality of care. Veterans Integrated Service Network (VISN) Directors are responsible for ensuring compliance with all standards in VHA Handbook 1162.02 for all DRRTPs in their VISN. The Medical Center Director is responsible for appointing a Chief, DRRTP. The Chief, DRRTP is responsible for all aspects of a comprehensive program of clinical care, the efficient and effective operation of the domiciliary, and providing quality care in a safe environment, including preparation of the Annual Narrative Report, which includes the ASSA.

In FY 2009, VHA plans to use a contractor to assess safety, security, and privacy at all domiciliaries as part of the Mental Health Residential Rehabilitation Treatment Programs (MHRRTP) Transformation Plan. The plan will transform the DRRTP and the Psychosocial Residential Rehabilitation and Treatment Program (PRRTP) into one unified program. As part of the transformation, DRRTP has drafted a new MHRRTP VHA Handbook, which will combine VHA Handbook 1162.02 and VHA Handbook 1162.03, "Psychosocial Residential Rehabilitation and Treatment Program." In February 2007, the draft VHA MHRRTP Handbook was internally distributed for feedback and review. However, the draft handbook is not expected to be finalized until the first quarter of FY 2009. The draft VHA MHRRTP Handbook addresses more safety, security, and privacy concerns than VHA Handbook 1162.02.

Results

VHA needs to implement additional national procedures and clarify national guidance to ensure that safety, security, and privacy issues are sufficiently identified, reported, and corrected throughout the year. VHA is in the process of issuing revised national procedures in its draft VHA MHRRTP Handbook, but needs action to finalize these procedures. Our audit included site visits at five domiciliaries and disclosed three national issues that impact all 49 domiciliaries: (1) there is a need to establish national

procedures for the inspections of veterans' rooms; (2) additional safety, security, and privacy procedures are needed for female veterans along with security initiatives for all veteran residents; and, (3) improvements are needed in annual safety, security, and privacy reporting as well as the follow-up process. Overall, VHA safety, security, and privacy at domiciliaries warrant attention and remediation.

Issue 1: Need to Establish National Procedures for Veterans' Room Inspections.

Unsecured medications were found in veterans' domiciliary rooms during room inspections we conducted at all five domiciliaries. There are no national procedures for room inspections at domiciliaries. In addition, we found that a physical security survey for controlled substances was not conducted at one of the nation's largest domiciliaries.

National procedures for periodic unannounced inspections and random searches of all storage areas in veterans' rooms are needed. We identified unsecured medications at all five facilities. We accompanied VHA staff on random inspections of veterans' rooms and identified 17 instances of unsecured medications during 60 room observations at five facilities that should have been secured in the veterans' personal locked storage areas. Currently, VHA has no policy requiring room inspections. However, the draft VHA MHRRTP Handbook for all MHRRTPs does include requirements for regular and random health and welfare inspections of resident rooms and random contraband inspections. Local procedures for room inspections varied and did not include periodic unannounced room inspections of all unsecured storage areas for all veterans' rooms. In fact, 6 of 47 domiciliaries did not have written procedures for contraband detection with random searches occurring regularly. Periodic unannounced inspections of storage areas at domiciliaries would provide greater security over medications and reduce the risk of loss, theft, misuse, and abuse. Proper security of medications is a crucial aspect to ensuring the safety and security of all veterans.

A physical security survey of controlled substance security at one domiciliary was not conducted in FY 2007. VHA needs to ensure that physical security surveys are conducted at domiciliaries that store controlled substances. We also found that the medical center police did not include the domiciliary in its physical security survey. According to the domiciliary, approximately 92 percent of its population has substance abuse issues, which puts this domiciliary at high risk for misuse of controlled substances. We also noted that the ASSA does not include a question related to this requirement and the Chief, DRRTP was not aware of it. Physical security surveys are an important requirement for facilities that store and dispense controlled substances.

Issue 2: Need for Additional Safety, Security, and Privacy Procedures for Female Veterans and Guidance on Security Initiatives for All Veteran Residents.

Our results showed that female veterans are subject to different levels of safety, security, and privacy. VHA Handbook 1162.02 does not specifically address any special safety, security, and privacy needs of female veterans although the ASSA includes two questions

specific to female veterans. However, the draft VHA MHRRTP Handbook does address safety, security, and privacy needs specific to female veterans. We found that not all domiciliaries have bedroom and bathroom locks for female veterans, and the potential for unauthorized access to bedrooms through ceilings existed at two domiciliaries. In the FY 2007 ASSA, 8 of 47 facilities responded that the facility did not have female bedroom and bathroom locks and 3 facilities responded that the facility only partially addressed this question. Two Chiefs, DRRTP cited safety concerns as the reasons for not installing bathroom locks. The lack of specific policy requirements for safety, security, and privacy for female veterans increases the risk of harm to this population.

Domiciliaries have made limited progress implementing VHA's resident national security initiative of January 2008 that required immediate implementation of key card systems on perimeter doors, programmable key card systems on female bedroom doors, and/or closed circuit monitoring systems. As of June 30, 2008, 19 domiciliaries had not implemented key card systems on female doors or closed circuit monitoring systems, and 38 domiciliaries had not implemented key card systems on entryways and exits of perimeter doors.

The guidance directed actions be taken immediately but did not include actual target dates for implementation actions. Target dates need to be established to help ensure this major national veteran safety and security initiative is implemented. In April 2008, the Director of RRTP redirected all Chiefs, DRRTP that all funds for keyless entry must be used in FY 2008 and all keyless entry projects must be completed by the end of FY 2008. During our visits to the five domiciliaries, we determined that three facilities did not have keyless entry on female doors or closed circuit monitoring systems, and all five facilities had not installed key card systems on perimeter doors. In the FY 2007 ASSA, 6 of 47 facilities responded that the facility did not have closed circuit monitoring or security mirrors in hallways and 9 facilities responded that the facility only partially met this question. The safety and security of all veterans, and especially female veterans, is jeopardized if these resident security requirements are not implemented.

Issue 3: Need to Improve Annual Safety, Security, and Privacy Reporting and Follow-Up Process.

Current, accurate, and complete annual reporting of all safety, security, and privacy issues is extremely important to the success of the DRRTP's efforts to establish procedures to ensure a safe, secure, and private environment. Proper identification and remediation of significant safety, security, and privacy areas is jeopardized if responses to the ASSA are not accurate, all required staff do not provide input into the ASSA, and independent follow-up of corrective actions taken does not occur.

We identified 12 local ASSA safety and security issues at the five domiciliaries we visited. At three of the facilities, eight of the 12 issues were reported as met on the FY 2007 ASSA when they should have been reported as partially met. The incorrect responses at these facilities decreases the reliability of the FY 2007 ASSA. (For

additional information, see Appendix A.) There are no national procedures to validate that domiciliaries are reporting correct ASSA responses.

We also noted that all required medical center staff tasked with completing the annual ASSA did not provide input. We observed this reporting weakness at four of the five facilities. The Chief, DRRTP is responsible for completing the ASSA with input from seven medical center staff members. Reporting controls need strengthening to ensure ASSAs are completed by the required medical center staff.

In addition, there are no procedures to ensure that issues identified and reported by domiciliaries have been corrected. Safety, security, and privacy issues may not be promptly remediated without independent follow-up to determine if corrective actions have been taken. Some domiciliaries did not submit the narrative portion of the Annual Narrative Report required by VHA Handbook 1162.02. The potential exists that all safety, security, and privacy issues are not fully explained or reported if the narrative portion of the Annual Narrative Report is not provided to the Director of RRTP. The annual reporting requirements need to be consistent with the current handbook.

Conclusion

Safety, security, and privacy at VHA domiciliaries are a nationwide concern. In addition, some local safety and security issues also warrant management's attention. Substantive problems exist in three main areas. Unannounced room inspections are needed to prevent substance abuse and the misuse of controlled substances. Safety, security and privacy for female veterans and security for all residents need to be enhanced. Annual safety, security, and privacy reporting and follow-up need to be improved. To ensure all veteran domiciliary residents are cared for within an environment where they feel safe and secure and without problems related to privacy, immediate action regarding these issues is imperative. Implementation of the draft VHA MHRRTP Handbook and planned assessments of safety, security, and privacy at all domiciliaries in FY 2009 as part of the MHRRTP Transformation Plan would result in improved safety, security, and privacy for residents at domiciliaries.

Recommendations

1. We recommend the Under Secretary for Health revise procedures that require domiciliaries to conduct periodic unannounced inspections and random searches of all storage areas in veterans' rooms to identify unsecured medication.

2. We recommend the Assistant Secretary for Operations, Security, and Preparedness strengthen controls to ensure physical security surveys are conducted at domiciliaries with controlled substances.

3. We recommend the Under Secretary for Health establish target dates for the installation of key card systems on entryways and exits of perimeter doors and

programmable key card systems on female bedroom doors and/or closed circuit monitoring systems at all domiciliaries.

4. We recommend the Under Secretary for Health revise procedures to address safety, security, and privacy issues unique to female veterans and revise the ASSA to address these issues.

5. We recommend the Under Secretary for Health perform a study to assess the feasibility of implementing floor-to-ceiling construction or appropriate alternative security measures at domiciliaries to prevent unauthorized access between rooms.

6. We recommend the Under Secretary for Health revise procedures to ensure that domiciliaries are reporting correct ASSA responses that are completed by the appropriate medical center staff.

7. We recommend the Under Secretary for Health revise procedures to ensure that safety, security, and privacy issues identified and reported by domiciliaries have been corrected.

8. We recommend the Under Secretary for Health ensure the complete submission of Annual Narrative Reports or revise procedures to include a narrative section for the ASSA.

Under Secretary for Health Comments

The Under Secretary for Health agreed with our findings and recommendations made to VHA and provided acceptable implementation plans (See Appendix E for the full text of the Under Secretary's comments and target dates for action plans.) The Under Secretary stated that the draft VHA MHRRTP Handbook would be finalized by the end of the first quarter of FY 2009. This handbook directs program managers to conduct regular and random room inspections, including inspections of storage areas. Also, written procedures will be developed to detect contraband brought on the unit, and there will be health and welfare inspections of veterans' belongings at admission and regular and random unit and locker inspections.

The Under Secretary reported that the Deputy Under Secretary for Health for Operations and Management issued an additional directive for the key card resident security initiative that established a firm target date of September 30, 2008. For those VISNs reporting estimated completion dates beyond the deadline, monthly status updates to the MHRRTP program office will be required until full safety system installation is complete. The draft VHA MHRRTP Handbook devotes an entire section to the special needs of female veterans. In addition, the ASSA process was revised to further address female veterans' areas. Lastly, the Office of Mental Health Services will evaluate the feasibility of safety alternatives to address over-the-wall entry.

Further, the Under Secretary commented that the ASSA will be revised to include certification of participation by the team members. Medical Center directors will be required to certify the accuracy of the ASSA and outline an action plan and timeframes for items not met or partially met. VHA has finalized contract award negotiations with a contractor to complete a site survey of all MHRRTPs to assess compliance with the MHRRTP Transformation Plan and the draft VHA MHRRTP Handbook. In addition, VHA's Systematic Ongoing Assessment and Review Strategy will begin to assess safety, security, and privacy actions as part of their regularly scheduled site visits to facilities with domiciliaries and all domiciliaries will be required to obtain accreditation by the Commission on Accreditation of Rehabilitation Facilities by 2011. The Under Secretary reported that the Annual Narrative Report has been replaced by an Annual Survey, which includes a narrative section for the ASSA.

Assistant Secretary of Operations, Security, and Preparedness Comments

The Assistant Secretary for Operations, Security, and Preparedness agreed with our finding and recommendation and provided an acceptable implementation plan (See Appendix F for the full text of the Assistant Secretary's comments.) The Assistant Secretary reported that additional language will be added to the current draft of VA Directive and Handbook 0730/1, Appendix B, "Physical Security Requirements and Options," which will include regular consultations with unit Chiefs and facility officials responsible for narcotics inventories and reviews for compliance during routine inspections or other reviews. In addition, VA's Law Enforcement Training Center (VA LETC) Training Unit #11, "Physical Security" will be updated to incorporate domiciliaries, including new training material that will contain requirements for safeguarding controlled substances.

OIG Response

The implementation of the draft VHA MHRRTP Handbook and implementation of additional future planned actions noted in the Under Secretary's response address all of our findings. We consider the planned actions acceptable and will follow up on their implementation.

(original signed by:)

BELINDA J. FINN
Assistant Inspector General
for Auditing

Introduction

Purpose

The purpose of this audit was to assess how effectively VA has addressed safety, security, and privacy of veterans residing in VA domiciliaries. Specifically, we determined if the safety, security, and privacy issues identified by VHA at selected domiciliaries were corrected.

Background

The DRRTP is VA's oldest health care program and was initiated through legislation passed in the late 1860's to provide a home for disabled volunteer soldiers of the Civil War. Domiciliary care was initially established to provide services to economically disadvantaged veterans, and it remains committed to serving that group. The domiciliary has evolved from a "soldiers' home" to become an active clinical rehabilitation and treatment program for veterans.

The mission of the DRRTP is to provide coordinated, integrated, rehabilitative, and restorative clinical care in a bed-based program. The goal of DRRTP is to help eligible veterans achieve and maintain the highest level of functioning and independence possible. In 2005, DRRTP became fully integrated with other residential rehabilitation and treatment programs within the Office of Mental Health Services. As of June 2008, there were 49 domiciliaries in 28 states. VHA plans to open four additional domiciliaries by the end of FY 2009.

VA's Office of Mental Health Services Homeless and Residential Rehabilitation and Treatment Services section was charged by the National Leadership Board's Health Systems Committee to review the status of care delivery in the MHRRTP and improve and enhance services to veterans. Several areas of improvement in MHRRTP were identified as key to securing a solid system of care. Some of the key elements identified were safety, security, and privacy enhancements within VA's domiciliaries. As a result, approximately $22.5 million was deployed to all domiciliaries for infrastructure and safety improvements from FY 2005 through 2008. DRRTP budgets were $334.2 million and $395.7 million for FY 2007 and 2008, respectively. The DRRTP budget for FY 2009 is projected to be $443.6 million, which is a 33 percent increase from FY 2007.

Domiciliary residents normally face many challenges such as homelessness, substance abuse, and mental illness. Substance abuse residents comprised approximately 66 percent of the domiciliary population during FY 2007. Domiciliary rooms normally accommodate two to four veterans and usually include beds, bedside drawers, desks, secured lockers (for all medications and other personal effects), and in some cases, an in-room bathroom.

Veteran safety issues within DRRTPs have recently come to the attention of the public and Congress. Members of Congress have also expressed concerns that VA domiciliary care programs meet the safety and capacity needs of women veterans. Female veterans represented approximately 4 percent of the total domiciliary population in FY 2007. In March 2006, VHA reported to the VA's Advisory Committee on Women Veterans that women veterans experienced a lack of privacy in the DRRTPs. The report also noted that women veterans often felt intimidated in the predominantly male facilities and were concerned for their safety.

VHA Handbook 1162.02, "Domiciliary Residential Rehabilitation and Treatment Program," dated April 3, 2006, establishes procedures for the domiciliaries. The handbook requires that staffing patterns and levels must ensure veterans' safety. In addition, it requires systems of control, such as sign-in and sign-out sheets, to ensure the knowledge of the veterans' whereabouts. DRRTP is in the process of preparing a revised VHA Handbook, which will combine VHA Handbook 1162.02 and VHA Handbook 1162.03, "Psychosocial Residential Rehabilitation and Treatment Program." In February 2007, the draft VHA MHRRTP Handbook was internally distributed for feedback and review. However, the draft handbook is not expected to be finalized until the first quarter of FY 2009. We noted that the revised handbook addresses more safety, security, and privacy concerns than VHA Handbook 1162.02.

VHA Handbook 1162.02 requires the Chief, DRRTP to complete an Annual Narrative Report that includes an ASSA. In FY 2002 to 2003, a National Domiciliary Task Force, which worked with VISN 5 and the Violence Prevention Technical Advisory Committee, developed the ASSA. In August 2007, a workgroup chaired by VA Central Office (VACO) and comprised of MHRRTP Field Advisory Board members revised the ASSA. The handbook requires each domiciliary to identify any safety, security, and privacy concerns as part of the annual reporting requirements and includes an action plan with a timeline for remediation of problem areas. The ASSA consists of 32 questions to be completed by the Chief, DRRTP and other medical center staff and is used as a planning tool to identify potential safety, security, and privacy issues. Those questions noted as partially met or not met must be further explained in the comments and recommendations section of the ASSA. Chiefs, DRRTP may request funding based on the safety, security, and privacy needs identified in the ASSA. The Annual Narrative Report is submitted through the Medical Center Director to the VISN. The VISN prepares a Network Executive Summary, which identifies not met or partially met safety and security issues and submits the summary to the Director of DRRTP.

Based on VHA national data for FY 2007, 44 (94 percent) of 47 domiciliaries reported that their facility has at least one safety or security issue. The top five safety and security issues identified as not met in the FY 2007 ASSAs were:

1) No female bedroom or bathroom door locks (8 facilities);
2) Safety or security repair, renovation, or maintenance needs (7 facilities);

3) No closed circuit monitoring or security mirrors for hallways (6 facilities);
4) Hiding places around building (5 facilities); and
5) No sexual harassment training for residents (5 facilities).

On January 16, 2008, the Deputy Under Secretary for Health for Operations and Management provided guidance and authorized funds for the immediate implementation of key card systems on the entryways and exits of perimeter doors and programmable key card systems for female bedroom doors and/or closed circuit monitoring systems at all RRTPs to improve safety and security.

Management Oversight. The Director of RRTP is responsible for directing and overseeing the operation of the DRRTPs nationally. DFAB works collaboratively with VHA Central Office program staff to implement recommendations related to the DRRTPs. They also monitor DRRTPs to ensure that the safety and security of residents and other DRRTP areas of concern are addressed, such as the quality of care. VISN Directors are responsible for ensuring compliance with all standards in VHA Handbook 1162.02 for all DRRTPs in their VISN. The Medical Center Director is responsible for appointing a Chief, DRRTP. The Chief, DRRTP is responsible for all aspects of a comprehensive program of clinical care, the efficient and effective operation of the domiciliary, and for providing quality care in a safe environment. The Chief, DRRTP is also responsible for the preparation of the Annual Narrative Report, which includes the ASSA.

Scope and Methodology

The scope of the audit included a review of safety, security, and privacy issues identified by VA at domiciliaries from October 2006 through June 2008. We assessed the safety, security, and privacy environment at five randomly selected domiciliaries. We conducted site visits at the following five domiciliaries: Knoxville, IA; Chillicothe, OH; Cincinnati, OH; Little Rock, AR; and West Los Angeles, CA.

At each site, we reviewed the FY 2007 Annual Narrative Report including the ASSA and the related VISN Network Executive Summaries; each domiciliary's ASSA responses and compared their responses with local policies and procedures, local records, and the interior and exterior environment; local policies and procedures and medical center reports; and domiciliary inspection reports. We also interviewed domiciliary and medical center management and staff and participated in the inspection of veterans' bedrooms to determine the existence of unsecured medications and contraband.

We had meetings with the Director of the RRTP and the Associate Chief Consultant, Homeless and Residential Rehabilitation. We reviewed and summarized all the FY 2007 ASSAs for all 47 domiciliaries to identify reported safety, security, and privacy issues. We also obtained national demographic statistics to identify the population characteristics of the domiciliary population.

Our assessment of internal controls focused on those controls related to the audit objective. We conducted the audit in accordance with generally accepted government auditing standards. These standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Results and Conclusions

Issue 1: Need to Establish National Procedures for Veterans' Room Inspections

Findings

During our audit, we accompanied staff on random inspections of veterans' rooms and identified 17 instances of unsecured medications that were required to have been secured in the veterans' personal locked storage areas. The majority of medications found were in bedside drawers and were in pill or tablet form. (For an illustration of unsecured medications observed by OIG, see Appendix D.) A summary of the results of our inspections are shown below:

Site	OIG Inspection Date	# Rooms Observed	# Rooms Unsecured Medications
1	6/2/08	10	3
2	6/3/08	10	6
3	6/4/08	10	4
4	6/25/08	17	3
5	6/25/08	13	1
Total		60	17
		100%	28%

Room inspection procedures at the five facilities varied. For example, one site conducted weekly unannounced inspections while another site conducted weekly announced inspections.

VHA Handbook 1108.3, "Self-Medication Program," requires that "all self-medications (including controlled substances) must be kept in a locked cabinet or locker accessible only to the patient, the provider with prescriptive privileges, and/or qualified ward staff." Local policies for the five facilities incorporate these requirements and educate veterans about secure medication storage upon admission and periodically, such as in the event medications are unsecured. VHA Handbook 1162.02 requires that the Chief, DRRTP provide quality care in a safe environment. Proper security of medications is part of ensuring a safe environment.

Currently, VHA has no written policy requiring room inspections at domiciliaries. VHA Handbook 1162.02 does not address inspections or random searches and local policies for the five facilities did not include periodic unannounced room inspections of all unsecured

storage areas for all veterans' rooms. However, the draft VHA MHRRTP Handbook does include requirements for regular and random health and welfare inspections of resident rooms and random contraband inspections. Contraband searches may also result in the identification of unsecured medications. In the FY 2007 ASSA, 4 of 47 facilities responded that the facility did not have written procedures for contraband detection with random searches occurring regularly, and 2 facilities responded that the facility only partially addressed this question. In addition, two of the five facilities we visited only partially addressed this question even though they reported they had fully complied with it.

Unsecured medications are accessible to other veterans and staff, increasing the risk of theft and abuse. Approximately 66 percent of the domiciliary national population has substance abuse issues and most of the rooms with unsecured medications were occupied by two or more veterans.

We also found that one facility did not document the results of one major random search and that lockers found open during other inspections contained medications. Local policies for this facility required that inspection reports identify if medications are unsecured in veterans' rooms and open lockers. Domiciliary management did not provide sufficient oversight to ensure the search and inspections were documented. By not documenting the results of all inspections and searches, there is no evidence that safety and security issues are identified, tracked, and corrected. The Chief, DRRTP indicated that they will document the results of all major searches and the complete results of inspections in the future.

Physical Security Surveys at Domiciliary with Controlled Substances

One domiciliary was not included in the FY 2007 annual physical security survey. VHA Handbook 0730, "Security and Law Enforcement," dated August 11, 2000, requires annual physical security survey of specific areas in ward and treatment rooms (drug cabinets and refrigerators that contain controlled substances and medical supply rooms and closets) to ensure the effective planning and use of security resources. The Chief of Police did not include the domiciliary on the list of required review sites for the medical center and could not provide an explanation for excluding it.

The ASSA does not address annual physical security surveys and the Chief, DRRTP was not aware of this requirement. Physical security issues for controlled substances may not have been identified. According to the domiciliary, approximately 92 percent of its population has substance abuse issues, which puts this domiciliary at a high risk for misuse of controlled substances. One death occurred at the domiciliary in January 2007 from an apparent overdose of a controlled substance.

Conclusion

Periodic unannounced inspections of storage areas at domiciliaries would provide greater security over medications and reduce the risk of loss, theft, misuse, and abuse. Implementation of the draft VHA MHRRTP Handbook, which includes regular and random room inspections and random contraband inspections would result in improved security over medications. Physical security surveys are an important requirement for facilities that store and dispense controlled substances. Proper security of medications is a crucial aspect to ensuring the safety and security of all veterans, especially those with substance abuse issues.

Recommendations

1. We recommend the Under Secretary for Health revise procedures that require domiciliaries to conduct periodic unannounced inspections and random searches of all storage areas in veterans' rooms to identify unsecured medication.

2. We recommend the Assistant Secretary for Operations, Security, and Preparedness strengthen controls to ensure physical security surveys are conducted at domiciliaries with controlled substances.

Under Secretary for Health Comments

The Under Secretary for Health agreed with our finding and recommendation and plans to complete corrective action by December 2008. (See Appendix E for the full text of the Under Secretary's comments.) The Under Secretary reported that the draft VHA MHRRTP Handbook directs program managers to conduct regular and random room inspections, including inspections of storage areas. In addition, the Under Secretary reported that written procedures will be developed for detecting contraband brought on the unit, including inspections of veterans' belongings at admission and regular and random unit and locker inspections.

Assistant Secretary of Operations, Security, and Preparedness Comments

The Assistant Secretary of Operations, Security, and Preparedness agreed with our finding and recommendation and plans to complete corrective action by the 2nd quarter of FY 2009. (See Appendix F for the full text of the Assistant Secretary's comments.) The Assistant Secretary reported that additional language will be added to the current draft of VA Directive and Handbook 0730/1, Appendix B, "Physical Security Requirements and Options," which will include regular consultations with unit Chiefs and facility officials responsible for narcotics inventories and reviews for compliance during routine inspections or other reviews. In addition, VA's Law Enforcement Training Center (VA

LETC) Training Unit #11, "Physical Security" will be updated to incorporate domiciliaries, including new training material that will contain requirements for safeguarding controlled substances.

Office of Inspector General Comments

We consider these planned actions acceptable, and will follow up on their implementation.

Issue 2: Need for Additional Safety, Security, and Privacy Procedures for Female Veterans and Guidance on Security Initiatives for All Veteran Residents

Findings

Female veterans are subject to different levels of safety, security, and privacy. We found not all domiciliaries have bedroom and bathroom locks on female veterans' doors and possible unauthorized access to bedrooms through ceilings at two domiciliaries. In the FY 2007 ASSA, 8 of 47 facilities responded that the facility did not have female bedroom and bathroom locks and 3 facilities responded that the facility only partially addressed this question. In addition, we found that a facility had no locks on the common hallway female bathroom even though they reported they addressed this question. Two Chiefs, DRRTP cited safety concerns as the reasons for not installing bathroom locks.

VHA Handbook 1162.02 does not specifically address any safety, security, and privacy needs of female veterans. The ASSA includes two questions specifically related to females. One question asks if bedroom and bathroom locks are on female veterans' doors and another question asks if appropriate space is available for them to meet with children. The majority of veterans in domiciliaries are male and the lack of specific policy requirements for safety, security, and privacy that are unique to female veterans increases the risk of harm to this population. However, the draft VHA MHRRTP Handbook does address safety, security, and privacy needs specific to female veterans such as separate and secure sleeping arrangements.

On January 16, 2008, the Deputy Under Secretary for Health for Operations and Management provided guidance and authorized funds for the immediate implementation of key card systems on the entryways and exits of perimeter doors, programmable key card systems on female bedroom doors and/or closed circuit monitoring systems at all RRTPs to improve safety and security. This was cited as a "national priority" by the Deputy Under Secretary for Health for Operations and Management. As of June 30, 2008, 19 domiciliaries had not implemented key card systems on female bedroom doors or closed circuit monitoring and 38 domiciliaries had not implemented key card systems

on entryways and exits of perimeter doors. In the FY 2007 ASSA, 6 of 47 facilities responded that the facility did not have closed circuit monitoring or security mirrors in hallways and 9 facilities responded that the facility only partially addressed this question. During our site visits, we determined that three facilities did not have keyless entry or closed circuit monitoring of female bedroom doors and all five facilities had not installed key card systems on perimeter doors.

Locks on Female Bedroom and Bathroom Doors

We determined that one facility did not have any female bedroom or bathroom door locks and another facility did not have female bathroom door locks. In addition, one site did not have a bathroom door lock on the common hallway female bathroom; subsequently, the Chief, DRRTP had a lock installed on the common bathroom door during our site visit. The ASSA has a question to determine if all female bedrooms and bathrooms have locks on the doors.

Current policies do not require locks on female bedroom and bathroom doors. However, the January 16, 2008 guidance from the Deputy Under Secretary for Health for Operations and Management required the immediate implementation of programmable key card systems on female bedroom doors and/or closed circuit monitoring systems at all RRTPs. VHA Handbook 1162.02 requires that the Chief, DRRTP provide quality care in a safe environment.

Two Chiefs, DRRTP cited safety concerns as the reasons for not installing bathroom locks. Domiciliary management at the facility without any bedroom or bathroom locks considered increased monitoring to be effective and indicated that female veterans could jam mechanical locks, such as with paper, and lock themselves in the room. The risk of harm to females is significantly increased if females are not provided lockable bedroom and bathroom doors.

Resident Security Initiative

We determined that three facilities did not have keyless entry on female bedroom doors or closed circuit monitoring systems and all five facilities had not installed key card systems on perimeter doors. As of June 30, 2008, 19 domiciliaries had not implemented key card systems on female bedroom doors or closed circuit monitoring, and 38 domiciliaries had not implemented key card systems on entryways and exits of perimeter doors.

The January 16, 2008 guidance from the Deputy Under Secretary for Health for Operations and Management directed actions be taken immediately but did not include actual target dates for implementation. In April 2008, the Director of RRTP redirected all Chiefs, DRRTP that all funds for keyless entry must be used in FY 2008 and all keyless entry projects must be completed by the end of FY 2008. Three facilities received funds

during February 2008 and the other two facilities received funds in April and May 2008, respectively. The reasons for non-implementation at the five facilities varied, especially for those sites that received funding in February 2008. For example, one site experienced delays, in part, because a proper control point for funds could not be determined. Another did not immediately implement the initiative because a target date was not provided in the guidance. The safety and security of all veterans, and especially female veterans, is jeopardized if these requirements are not implemented. Programmable key card systems increase safety and security by providing individually authorized access that can be terminated when necessary and allows for the continuous monitoring of veterans' entry and exit into their bedrooms and the building.

Possible Unauthorized Access via Ceiling

The bedroom walls at one site did not extend from the floor to the building ceiling (floor-to-ceiling construction). The bedrooms have drop ceilings and an approximate four foot space above the top of the bedroom wall to the building ceiling. This issue was identified during an annual physical security survey and was not included on the ASSA. Subsequently, we identified another facility that did not have floor-to-ceiling construction. VHA Handbook 1162.02 requires that the Chief, DRRTP provide quality care in a safe environment. The handbook does not address floor-to-ceiling construction. One of the ASSA questions assesses if the facility provides adequate visual and auditory privacy in bedrooms and treatment areas.

This condition has not been identified and addressed as a safety, security, and privacy issue by DRRTP management. VHA Handbook 0730 requires floor-to-ceiling construction for agent cashier and pharmacy areas. This open space above the ceiling creates the risk of unauthorized physical or visual access to female veterans' bedrooms.

Conclusion

Female veterans are subject to different levels of safety, security, and privacy. This results in inconsistent treatment of this higher risk population and jeopardizes the safety, security, and privacy of female veterans. Safety, security, and privacy procedures for female veterans would ensure that they have an equal level of security as male veterans at domiciliaries. The implementation of the draft VHA MHRRTP Handbook would result in improved safety, security, and privacy for female veterans. DRRTP management did not establish a firm implementation target date for the resident security initiative and the decision to extend the implementation to the end of FY 2008 has only resulted in limited implementation. Most of the domiciliaries received funds during February 2008 and implementation should have progressed immediately as indicated by the Deputy Under Secretary for Health for Operations and Management.

Recommendations

3. We recommend the Under Secretary for Health establish target dates for the installation of key card systems on entryways and exits of perimeter doors and programmable key card systems on female bedroom doors and/or closed circuit monitoring systems at all domiciliaries.

4. We recommend the Under Secretary for Health revise procedures to address safety, security, and privacy issues unique to female veterans and revise the ASSA to address these issues.

5. We recommend the Under Secretary for Health perform a study to assess the feasibility of implementing floor-to-ceiling construction or appropriate alternative security measures at domiciliaries to prevent unauthorized access between rooms.

Under Secretary for Health Comments

The Under Secretary for Health agreed with our findings and recommendations and plans to complete all corrective actions by the end of the first quarter of FY 2009. (See Appendix E for the full text of the Under Secretary's comments.) The Under Secretary reported that the Deputy Under Secretary for Health for Operations and Management issued an additional directive for the resident security initiative that established a firm target date of September 30, 2008. The new draft VHA MHRRTP Handbook devotes an entire section for the special needs of female veterans. In addition, the Under Secretary reported that the ASSA process has been revised to further address female veterans' areas, Lastly, the Office of Mental Health Services will evaluate the feasibility of safety alternatives to address over-the-wall entry.

Office of Inspector General Comments

We consider these planned actions acceptable, and will follow up on their implementation.

Issue 3: Need to Improve Annual Safety, Security, and Privacy Reporting and Follow-Up Process

Findings

We identified conditions that impact safety, security, and privacy but were not reported on the 2007 ASSA. We also noted that some of the seven medical center staff required to participate in the annual ASSA did not provide inputs at four of the five facilities we visited. VHA Handbook 1162.02 requires the Chief, DRRTP to complete an ASSA and a

memorandum from Deputy Under Secretary for Health for Operations and Management requires input from specific medical center staff. Controls are not sufficient to validate domiciliaries are reporting correct ASSA responses that are completed by the required medical center staff. In addition, there are no independent follow-up procedures to ensure that issues identified and reported by domiciliaries have been corrected. Proper identification of significant safety, security, and privacy issues is jeopardized if responses to the ASSA are not completely accurate and all required staff do not provide input into the ASSA. Safety, security, and privacy issues may not be promptly remediated without independent follow-up to determine if corrective actions have been taken.

In addition, some domiciliaries did not submit the narrative portion of the Annual Narrative Report, which is required by VHA Handbook 1162.02. The Director of RRTP informed domiciliaries that the narrative portion of the Annual Narrative Report was not needed. The narrative portion of the report includes major program information such as program successes, failures, and challenges. All safety, security, and privacy issues may not be fully explained if the narrative portion of the Annual Narrative Report is not provided to Director of the RRTP.

The Director of RRTP stated that they plan to use a contractor to assess safety, security, and privacy at all domiciliaries in FY 2009 as part of the MHRRTP Transformation Plan. The MHRRTP National Transformation Plan will transform PRRTP and DRRTP into one unified program.

Inaccurate and Incomplete Annual Safety and Security Assessments

Three of the five facilities provided inaccurate responses to the ASSA. They responded that certain safety, security, and privacy issues were met, but we believe they should have been reported as partially met or not met. We identified eight conditions that should have been reported and were not at these three facilities. (For additional information, see Appendix A.)

VHA Handbook 1162.02 requires the Chief, DRRTP to complete an Annual Narrative Report, which includes an ASSA. The ASSA consists of 32 questions that are to be completed by the Chief, DRRTP and other individuals and is used as a planning tool to identify potential safety, security, and privacy issues. Questions noted as partially met or not met must be addressed in the comments and recommendations section and must include an action plan with a timeline for remediation of problem areas. There are no procedures to validate domiciliaries are reporting correct ASSA responses. The Chiefs, DRRTP at the three facilities did not fully ensure that their ASSA responses were accurate and reflected the current conditions. The safety and security of veterans is jeopardized if all problem areas are not identified and corrected.

In addition, we determined that the required medical center staff did not provide input into the ASSA at four facilities. On November 8, 2007, the Deputy Under Secretary for

Health for Operations and Management provided guidance that required the Chief, DRRTP to complete the ASSA based on the input from seven required staff. Staff includes the Patient Safety Officer, Engineering staff, Women Veteran Representative, Medical Center Safety Officer, Infection Control Nurse, Police Service representative, and a Quality Improvement representative. Controls are not sufficient to validate ASSAs are completed by the appropriate medical center staff. The main reason for non-participation was management oversight. If input is not provided by all team members, all safety, security, and privacy issues may not be identified and corrected.

No Independent Follow-Up of ASSA Issues

Safety, security, and privacy issues reported by domiciliaries in the ASSA are not independently assessed to determine if issues have been corrected. There are no procedures to ensure that ASSA issues identified and reported by domiciliaries have been corrected. VHA Handbook 1162.02 requires that questions noted as partially met or not met must be addressed in the comments and recommendations section of the ASSA and must include an action plan with a timeline for remediation of problem areas. The Director of RRTP is responsible for directing and overseeing DRRTPs nationally and safety, security, and privacy issues are discussed during national teleconference calls with Chiefs, DRRTP. Safety, security, and privacy issues may not be promptly remediated without independent follow-up to determine if corrective actions have been taken.

Annual Narrative Report

Four of the five facilities did not submit the narrative portion of the Annual Narrative Report in FY 2007. VHA Handbook 1162.02 requires the Chief, DRRTP to prepare and submit an Annual Narrative Report. The Annual Narrative Report is submitted through the Medical Center Director and to the VISN. The VISN prepares a Network Executive Summary that identifies not met or partially met safety and security issues and submits the summary to the Director of RRTP.

The report includes basic program information having administrative or clinical significance such as program philosophy and types of veterans served. It includes the ASSA and the narrative portion that includes major program information such as program successes, failures, and challenges. Some domiciliaries describe significant safety, security, and privacy issues and identify additional issues not included in the ASSA in the narrative portion. For example, one domiciliary identified issues and recommendations related to searches of resident belongings upon admission in the narrative portion.

During FY 2007, domiciliaries were redirected by the Director of RRTP to complete an Annual Survey in lieu of the narrative portion of the Annual Narrative Report. The Annual Survey provides similar information to that required by the Annual Narrative Report but does not address major program information, such as program successes and failures. The Director of RRTP explained that the narrative portion of the Annual

Narrative Report was no longer needed. As a result, the Director of RRTP may not receive all information having administrative or clinical significance including detailed descriptions of significant safety, security, and privacy issues.

Conclusion

Current, accurate, and complete annual reporting of all safety, security, and privacy issues is extremely important to the success of the DRRTP's efforts to establish procedures to ensure a safe, secure, and private environment. Chiefs, DRRTP need to ensure that ASSA responses are accurate and that all required staff participate in its completion. Inaccurate reporting and/or non-participation by required staff could impact management's ability to identify significant safety, security, or privacy issues. Incorrect responses identified at these three facilities decreases the reliability of the FY 2007 ASSA responses. Independent follow-up of reported safety, security, and privacy issues ensures that appropriate corrective actions have been taken. The annual reporting requirements should be consistent with the current handbook. The narrative portion of the Annual Narrative Report should be helpful to the Director of RRTP and provide further background to significant safety, security, and privacy issues.

Recommendations

6. We recommend the Under Secretary for Health revise procedures to ensure that domiciliaries are reporting correct ASSA responses that are completed by the appropriate medical center staff.

7. We recommend the Under Secretary for Health revise procedures to ensure that safety, security, and privacy issues identified and reported by domiciliaries have been corrected.

8. We recommend the Under Secretary for Health ensure the complete submission of Annual Narrative Reports or revise procedures to include a narrative section for the ASSA.

Under Secretary for Health Comments

The Under Secretary for Health agreed with our findings and recommendations and plans to complete all corrective actions by January 2011. (See Appendix E for the full text of the Under Secretary's comments.) The Under Secretary reported that the ASSA will be revised to include certification of participation and completion by the team members. In addition, the Medical Center Director will be required to certify the accuracy of the ASSA and prepare an action plan and timeframes for items not met or partially met. The target for completing these actions is February 2009. The Under Secretary reported that VHA has finalized contract award negotiations with a contractor to conduct a site survey of all MHRRTPs to assess compliance with the MHRRTP Transformation Plan and the

draft VHA MHRRTP Handbook. In addition, VHA's Systematic Ongoing Assessment and Review Strategy (SOARS) will begin to assess safety, security, and privacy actions as part of their regularly scheduled site visits to facilities with domiciliaries and all domiciliaries will be required to obtain accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) by 2011. The target for completing these actions is January 2011 and ongoing. The Under Secretary reported that the Annual Narrative Report has been replaced by an Annual Survey, which includes a narrative section for the ASSA. The target for completing these actions is January 2009 and ongoing.

Office of Inspector General Comments

We consider these planned actions acceptable, and will follow up on their implementation.

Appendix A

FY 2007 ASSA Issues Assessed by OIG

Domiciliary	ASSA #	ASSA Question	Reported by Facility	Assessed by OIG
Cincinnati, OH	1	All entries controlled by locks or automatically locking, alarmed, or overseen by a dedicated individual.	Met	Partially Met
	12	Each RRTP has written emergency plan that is updated annually.	Met	Partially Met
	14	There are written procedures for drug and alcohol monitoring include on-going random screenings.	Met	Partially Met
	15	There are written procedures for contraband detection with random searches occurring regularly.	Met	Partially Met
Chillicothe, OH	32	RRTPs may request funding for safety, security, privacy and access improvements or for repair, maintenance or furnishing needs. Submit a memo requesting funding that outlines and itemizes funding needs.	Not Met	Not Met
Knoxville, IA	17	All female veteran bedrooms and bathrooms have locks on their doors.	Not Met	Not Met
Little Rock, AR	12	Each RRTP has written emergency plan that is updated annually.	Met	Partially Met
	15	There are written procedures for contraband detection with random searches occurring regularly.	Met	Partially Met
	20	All MH RRTP employees are initially trained in workplace violence prevention and management including: emergency response plan, how to handle difficult persons, prevention or and how to defuse potentially violent situations, personal safety and self-defense.	Met	Partially Met
Los Angeles, CA	7	Parking lots and walkways have adequate lighting and are free of obstructions and hazards.	Partially Met	Partially Met
	17	All female veteran bedrooms and bathrooms have locks on their doors.	Met	Partially Met
	20	All MH RRTP employees are initially trained in workplace violence prevention and management including: emergency response plan, how to handle difficult persons, prevention or and how to defuse potentially violent situations, personal safety and self-defense.	Partially Met	Partially Met

Appendix B

FY 2007 ASSA Issues Reported by Domiciliaries

	ASSA #	ASSA Questions	Facilities Partially Met	Facilities Not Met	Total
1	32	RRTPs may request funding for safety, security, privacy and access improvements or for repair, maintenance or furnishing needs. Submit a memo requesting funding that outlines and itemizes funding needs.	N/A	N/A	24
2	29	The MH RRTP has no unmet safety or security repair, renovation, or maintenance needs.	15	7	22
3	4	The area surrounding the building is free of hiding places.	10	5	15
4	31	Closed circuit monitoring or security mirrors (convex mirrors) placed in hallways to view obstructed hallways and corners.	9	6	15
5	7	Parking lots and walkways have adequate lighting and are free of obstructions and hazards.	13	0	13
6	25	All entries controlled by locks or automatically locking, alarmed, or overseen by a dedicated individual.	9	2	11
7	1	All employee occupied areas support emergency calls for help, either through panic alarms, emergency telephone calls, or speed dial cell phone programming.	3	8	11
8	17	Electronic systems such as key card locks, magnetic doors, alarms, cameras function correctly and are tested on a schedule (Test systems to ensure accuracy).	11	0	11
9	5	All female veteran bedrooms and bathrooms have locks on their doors.	8	2	10
10	8	MH RRTP unit signage is current, visible, and contains visitor weapon and illicit drug and alcohol policies.	9	0	9
11	21	Each MH RRTP resident is provided sexual harassment prevention training as part of their orientation.	4	5	9
12	2	A system to track the location of the residents and monitor visitors is developed and maintained.	5	2	7
13	12	Each RRTP has written emergency plan that is updated annually.	7	0	7
14	11	Adverse event data in a record keeping system are analyzed for the RRTP population, including patient to patient and patient to staff assault, missing patients, para-suicidal events, suicides, and mortality as evidenced by corrective action plans.	6	0	6
15	15	There are written procedures for contraband detection with random searches occurring regularly.	2	4	6
16	30	MH RRTP unit provides adequate privacy in bedrooms and treatment areas (visual & auditory).	6	0	6
17	3	Entrances to the building are clearly visible from the street or public throughfare.	3	2	5
18	18	Appropriate private space for female veteran to visit with children.	3	2	5
19	22	There is a plan for needed follow-up violence prevention training.	3	2	5
20	19	RRTP demonstrates attention to safety and security needs of frail elderly such as bedroom location, call buttons, bathroom design, etc.	3	0	3
21	6	Local external safety risks such as crime, traffic, drug use are assessed, minimized, and include patient education.	2	0	2
22	10	All adverse events are reported to the director, RRTP, VACO within 24 hours.	2	0	2
23	14	There are written procedures for drug and alcohol monitoring include on-going random screenings.	2	0	2
24	20	All MH RRTP employees are initially trained in workplace violence prevention and management including: emergency response plan, how to handle difficult persons, prevention or and how to defuse potentially violent situations, personal safety and self-defense.	2	0	2
25	23	The MH RRTP has written policies regarding violence in the workplace.	2	0	2
26	26	Private locked restrooms are available for staff.	2	0	2
27	28	MH RRTP unit is appropriately furnished to offer a home-like environment.	1	1	2
28	13	Staff and veterans are oriented to emergency plans and drills are conducted according to VA and Accrediting body standards.	1	0	1
29	16	Alcohol based products are monitored with abuse prone patients.	0	1	1
30	27	The unit meets all requirements in the appropriate chapter of the VA Life Safety Codes.	1	0	1
31	9	The RRTP is part of the medical center's adverse event data collection, reporting and record-keeping system.	0	0	0
32	24	Written policies/procedures are in effect on how to deal with aggressive/violent individuals.	0	0	0

Appendix C

Number of FY 2007 ASSA Issues Reported by Domiciliaries

				# Reported ASSA Issues		
#	VISN	Domiciliary	# Beds	Partially Met	Not Met	Total
1	1	Bedford, MA	40	0	1	1
2	1	Brockton, MA	46	5	1	6
3	2	Canandaigua, NY	50	5	2	7
4	2	Bath, NY	220	7	1	8
5	3	Brooklyn, NY	50	0	2	2
6	3	Lyons, NJ	85	0	1	1
7	3	Montrose, NY	123	2	0	2
8	4	Butler, PA	56	0	0	0
9	4	Pittsburgh, PA	65	3	0	3
10	4	Coatesville, PA	238	6	0	6
11	5	Perry Point, MD	50	2	0	2
12	5	Martinsburg, WV	312	3	0	3
13	6	Hampton, VA	169	8	3	11
14	7	Tuskegee, AL	43	1	6	7
15	7	Tuscaloosa, AL	48	2	1	3
16	7	Augusta, GA	60	2	0	2
17	7	Dublin, GA	136	3	0	3
18	8	Orlando, FL	60	6	1	7
19	8	Bay Pines, FL	65	3	3	6
20	9	Mountain Home, TN	295	4	1	5
21	10	Chillicothe, OH	50	0	1	1
22	10	Cincinnati, OH	82	0	0	0
23	10	Dayton, OH	115	6	4	10
24	10	Cleveland, OH	174	4	0	4
25	11	Battle Creek, MI	40	5	0	5
26	11	Detroit, MI	50	3	0	3
27	12	North Chicago, IL	105	0	0	0
28	12	Milwaukee, WI	356	3	1	4
29	15	St. Louis, MO	50	1	2	3
30	15	Leavenworth, KS	178	2	2	4
31	16	Little Rock, AR	126	1	0	1
32	17	Dallas, TX	40	3	5	8
33	17	San Antonio, TX	40	2	0	2
34	17	Bonham, TX	224	3	2	5
35	17	Temple, TX	408	6	2	8
36	18	Albuquerque, AZ	40	9	0	9
37	18	Prescott, AZ	120	2	1	3
38	19	Sheridan, WY	40	5	1	6
39	20	Anchorage, AK	50	0	1	1
40	20	American Lake, WA	60	6	1	7
41	20	White City, OR	600	1	0	1
42	21	Palo Alto, CA	100	0	1	1
43	22	Los Angeles, CA	321	4	0	4
44	23	Des Moines, IA	38	5	0	5
45	23	Knoxville, IA	40	1	1	2
46	23	Hot Springs, SD	100	8	1	9
47	23	St. Cloud, MN	103	2	0	2
		TOTAL	5,861	144	49	193
48	8	Tampa, FL	35	Opened June 2008		
49	18	Big Springs., TX	40	Opened April 2008		
		TOTAL	5,936	N/A	N/A	N/A

Appendix D

Illustration of Unsecured Medications Observed by OIG

This includes VA and Non-VA medications. These medications are not controlled substances.

Appendix E

Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: September 26, 2008

From: Under Secretary for Health (10)

Subj: OIG Draft Report: **Audit of the Veterans Health Administration's Domiciliary Safety, Security, and Privacy** (Project No. 2008-01030-R4-0120/ WebCIMS 411303)

To: Assistant Inspector General for Auditing (52)

1. I have reviewed your draft report. Based on the revisions you made in response to concerns raised by VHA to the initial draft document, I concur with your findings and recommendations. The collegial efforts of your staff in resolving points of contention are appreciated, and I believe that the revised report provides a more balanced and accurate representation of VHA's ongoing efforts to address the important issues you raise. Our plan of corrective action to each of the report recommendations is attached.

2. VHA fully recognizes that residential rehabilitation, including the Domiciliary Residential Rehabilitation Treatment Programs (DRRTP), is a vital component of our overall continuum of mental health services. We have long acknowledged that the concerns cited by your auditors must be rectified. As a system, we made significant strides during the past several years in developing a national plan to improve and enhance DRRTP services to veterans, especially in the areas of safety, security and privacy. In Fiscal Year 2007, VHA 's National Leadership Board charged a national committee, composed of program experts from all levels of the organization, to review the current status of care delivery of residential rehabilitation treatment services. As part of its charge, the committee developed a Mental Health RRTP Transformation Plan that outlines national clinical and administrative recommendations, including standardized safety, security and privacy improvements, that would apply to all of our residential programs. VHA leadership approved the plan in August 2007 and it is now being implemented nationwide.

3. The comprehensive plan, which was shared with your auditors, identifies numerous areas of focus, including safety, security and privacy, among others. It also emphasizes that credible oversight systems must be developed to ensure that established standards of care are actually being implemented. Since approval of the plan, VHA has provided considerable resources to improve patient care in our residential rehabilitation programs. For example, approximately $15 million has already been awarded to the DRRTPs to enhance

safety, security, privacy and supervision. The Deputy Under Secretary for Health for Operations and Management (DUSHOM) also issued field guidance directing medical centers to comply with national policies requiring continual on-site supervision at all residential treatment sites. More than $11 million was distributed to the field to address identified deficiencies related to round-the-clock supervision on residential units. In addition, all treatment programs are now required to achieve and maintain accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) by the year 2011. The Office of Mental Health Services, in conjunction with the Employee Education System, has already sponsored four regional CARF training sessions for VHA management and clinical staff to prepare for the accreditation process.

4. VHA's goal is to redefine its various mental health residential treatment specialties as one unified treatment program. In support of this goal, we developed a new Mental Health Residential Rehabilitation Treatment Program Handbook, which provides structured, concrete and prescriptive guidance for all programs, including domiciliaries, while still affording individual facilities the ability to enhance services based on local population needs. The new draft handbook, which is currently undergoing final concurrence, is expected to be finalized for field distribution during the first quarter of Fiscal Year 2009. In February 2008, VHA convened a national educational conference for residential rehabilitation program managers to provide initial guidance in understanding and implementing requirements defined in the handbook. Your auditors were provided with a copy of the draft handbook, and they acknowledged that all of the issues raised in your report were adequately addressed in the new document.

5. I must reiterate the importance of program oversight and monitoring to ensure that established standards of care are being implemented by our facilities, and VHA Is also taking specific steps in this important area. We recently finalized a national contract award with an outside contractor to complete on-site reviews of all 188 mental health residential treatment programs at 104 sites to assess and evaluate the successful implementation of requirements specified in both the Transformation Plan and the new policy handbook. Residential environment of care, safety, security and privacy assessments, as well as the specialized needs of women veterans and safe medication management, will be highlighted in these assessments, which are anticipated to begin on October 1, 2008. In addition, MHRRTP program managers have partnered with the VHA SOARS (Systematic, Ongoing Assessment and Review Strategy) national program office to include the MHRRTPs in the SOARS program reviews. A SOARS assessment guide was developed and piloted at several residential treatment programs in the second and third quarters of Fiscal Year 2008. Actual reviews are anticipated to begin in October 2008.

Page 3

OIG Draft Report: **Audit of the Veterans Health Administration's Domiciliary Safety, Security, and Privacy** (WebCIMS 411303)

6. In summary, as our actions confirm, VHA is fully committed to ensuring that veterans in our DRRTPs receive the highest levels of quality care. Your report has confirmed areas needing improvement that VHA has also identified, and your observations have assisted us in prioritizing program improvement needs. If additional information is required, please contact Margaret M. Seleski, Director, Management Review Service (10B5), at 461-8470.

Michael J. Kussman M.D.
Michael J. Kussman, MD, MS, MACP

Attachment

Under Secretary for Health Comments to Office of Inspector General's Report

The following comments are submitted in response to the recommendations in the Office of Inspector General's Report:

OIG Recommendations

1. We recommend the Under Secretary for Health revise procedures that require domiciliaries to conduct periodic unannounced inspections and random searches of all storage areas in veterans' rooms to identify unsecured medication.

Concur **Target Completion Date:** December 2008
Status: In Process

The new draft VHA Mental Health Residential Rehabilitation Treatment Program (MHRRTP) Handbook, anticipated to be finalized for field distribution in the first quarter of FY 2009, directs all MHRRTP program managers to implement regular and random room inspections that include storage areas. Procedures direct staff to not only identify unsecured medication, but also to develop written procedures for detecting contraband brought on the unit. These procedures will include health and welfare inspections of veterans' belongings at admission and regular and random unit and locker inspections.

2. We recommend the Assistant Secretary for Operations, Security, and Preparedness strengthen controls to ensure physical security surveys are conducted at domiciliaries with controlled substances.

Concur

No VHA action required; an action plan will be submitted to OIG by the Assistant Secretary for Operations, Security, and Preparedness in consultation with VHA.

3. We recommend the Under Secretary for Health establish target dates for the installation of key card systems on entryways and exits of perimeter doors and programmable key card systems on female bedroom doors and/or closed circuit monitoring systems at all domiciliaries.

Concur **Target Completion Date:** Sept. 30, 2008 and Ongoing
Status: In Process

As cited in the report, a memo dated January 16, 2008, was sent by the Deputy Under Secretary for Health for Operations and Management (DUSHOM) directing facilities to immediately implement key card systems on perimeter doors, programmable key card systems on female bedroom doors and/or closed circuit monitoring systems. A follow-up memo was also submitted to the field to reassert this direction. On July 16, 2008, an additional DUSHOM directive was submitted to field facilities establishing a target date of completion for September 30, 2008. All VISNs were required to report detailed progress of implementation and estimated completion dates. For those VISNs reporting estimated completion dates beyond the deadline, monthly status updates to the MHRRTP program office will be required until full safety system installation is complete.

4. We recommend the Under Secretary for Health revise procedures to address safety, security, and privacy issues unique to female veterans and revise the ASSA to address these issues.

Concur **Target Completion Date:** December 2008 and Ongoing
Status: In Process

As already reported, the executive report of "The Transformation of Mental Health Residential Rehabilitation & Treatment Programs" outlines plans to improve safety, security and privacy in all residential environments. VHA is currently in the process of implementing additional national procedures through the draft MHRRTP Handbook, which devotes an entire section (Section 13) to the special needs of female veterans. The Annual Safety and Security Assessment (ASSA) has also been revised to include locks on female bedroom and bathroom doors, provision of a separate, secure area of the facility near staff offices, and a section to include narrative comments. The ASSA will be conducted jointly with the facility's women veteran's program manager, who will also

participate in regular environmental rounds, with special emphasis on improving privacy and security.

5. We recommend the Under Secretary for Health perform a study to assess the feasibility of implementing floor-to-ceiling construction or appropriate alternative security measures at domiciliaries to prevent unauthorized access between rooms.

Concur **Target Completion Date:** December 2008
Status: Planned

There are more than 35,000 discharges from MHRRTPs annually, and there has never been an incident reported of over-the-wall entry to a resident room. There are significant budgetary implications related to renovation and construction of floor-to-ceiling walls. Nevertheless, alternative measures, such as installation of panic alarms, will be explored. The Office of Mental Health will also consult with engineering, patient safety and law enforcement program experts to assess the feasibility of various safety options to address this concern.

6. We recommend the Under Secretary for Health revise procedures to ensure that domiciliaries are reporting correct ASSA responses that are completed by the appropriate medical center staff.

Concur **Target Completion Date:** February 2009
Status: Planned

The Annual Safety and Security Assessment (ASSA) will be revised to include signature blocks for all team members, with a statement certifying that they participated in the review and agree with the results. The new assessment tool will include clear directions on how to complete the survey. There will also be a requirement that the medical center director sign a cover memo certifying accuracy and outlining an action plan, including completion timeframes, for each item not met or partially met. This information will then be submitted to each VISN for appropriate follow-up and reporting to appropriate VACO program officials.

7. We recommend the Under Secretary for Health revise procedures to ensure that safety, security, and privacy issues identified and reported by domiciliaries have been corrected.

Concur **Target Completion Date:** January 2011 and Ongoing
Status: In Process

As already reported, VHA has finalized contract award negotiations with an outside contractor to complete a comprehensive site survey of all 188 mental health residential treatment programs to assess compliance with mandates cited in both the Transformation Plan and the new draft MHRRTP Handbook. VHA's SOARS program will also begin to assess various safety, security and privacy compliance actions as part of their regularly scheduled site visits to facilities with domiciliary residential treatment programs. As part of its ongoing national educational conference series, the SOARS Program Office will sponsor a visual online conference call entitled "Assessing Mental Health Residential Rehabilitation and Training Programs." This live training session is scheduled for November 25, 2008, and will be attended by SOARS consultants, team leaders, Quality Management Officers, Chief Medical Officers and RRTP staff.

All domiciliaries will also be required to seek and maintain accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) by the year 2011.

8. We recommend the Under Secretary for Health ensure the complete submission of Annual Narrative Reports or revise procedures to include a narrative section for the ASSA.

Concur **Target Completion Date:** January 2009 and Ongoing
Status: In Process

The Annual Narrative Report has been replaced by the Northeast Program Evaluation Center (NEPEC) Annual Survey of domiciliary operations. The Fiscal Year 2008 annual survey, which will be distributed on October 1, 2008, is expected to be completed by January 1, 2009. The NEPEC survey instrument includes a narrative section for the annual safety and security assessment. All significant findings from the survey will be summarized by NEPEC and results will be provided to the Office of Mental Health Services for further review and follow-up action as indicated.

Appendix F

Assistant Secretary for Operations, Security, and Preparedness Comments

DEPARTMENT OF VETERANS AFFAIRS

Memorandum

Date: October 1, 2008

From: Assistant Secretary of Operations, Security and Preparedness (007)

Subj: Draft Audit Report of Veterans Health Administration's Domiciliary Safety, Security and Privacy (Project No. 2008-01030-R4-0120)

To: Inspector General (50)

1. We have reviewed the draft audit report (Project No. 2008-01030-R4-0120) concur with the following comments:

a. VA Directive and Handbook 0730/1, Appendix B, "Physical Security Requirements and Options" (August, 2004), already provides requirements for safeguarding controlled substances. To ensure existing policies are appropriately applied, the following language will be added to the current draft of Appendix B (due for publication in the 2nd quarter of FY 2009):

> "Domiciliary, Nursing Home Care units and other long-term residential care facilities are subject to existing VA physical security standards for the storing DEA Schedule II through V drugs. Such units will be surveyed annually as part of the facility physical security survey program. The VA Chief of Police Service will consult regularly with the Chiefs of these units, and with the facility official responsible for narcotics inventories. Compliance with these requirements will be reviewed during routine Office of Security and Law Enforcement program inspections or other reviews."

b. Procedures for annual physical security surveys are maintained in VA Law Enforcement Training Center (VA LETC) Training Unit #11, "Physical Security." This training unit will be updated to include VHA domiciliary units. The new training material will include requirements for safeguarding controlled substances, physical access control systems (PACS), and domiciliary buildings surveillance video protection.

2. Thank you for the opportunity to review and comment on this very important audit. We will continue to work with our VHA partners to provide safe and secure environments of care.

Kevin T. Hamilton

Charles L. Hopkins III

Assistant Secretary for Operations, Security, and Preparedness Comments to Office of Inspector General's Report

The following comments are submitted in response to the recommendations in the Office of Inspector General's Report:

OIG Recommendations

2. We recommend the Assistant Secretary for Operations, Security, and Preparedness strengthen controls to ensure physical security surveys are conducted at domiciliaries with controlled substances.

Concur **Target Completion Date:** 2nd Quarter FY 2009
Status: Planned

a. VA Directive and Handbook 0730/1, Appendix B, "Physical Security Requirements and Options" (August, 2004), already provides requirements for safeguarding controlled substances. To ensure existing policies are appropriately applied, the following language will be added to the current draft of Appendix B (due for publication in the 2nd quarter of FY 2009):

"Domiciliary, Nursing Home Care units and other long-term residential care facilities are subject to existing VA physical security standards for the storing DEA Schedule II through V drugs. Such units will be surveyed annually as part of the facility physical security survey program. The VA Chief of Police Service will consult regularly with the Chiefs of these units, and with the facility official responsible for narcotics inventories. Compliance with these requirements will be reviewed during routine Office of Security and Law Enforcement program inspections or other reviews."

b. Procedures for annual physical security surveys are maintained in VA Law Enforcement Training Center (VA LETC) Training Unit #11, "Physical Security." This training unit will be updated to include VHA domiciliary units. The new training material will include requirements for safeguarding controlled substances, physical access control systems (PACS), and domiciliary buildings surveillance video protection.

Appendix G

OIG Contact and Staff Acknowledgments

OIG Contact	Freddie Howell, Jr. (708) 202-2670
Acknowledgments	Joseph M. DeAntonis Mary Ann Fitzgerald Kevin Gibbons Raymond A. Jurkiewicz David Lakoskey John Pawlik Jennifer Roberts

Appendix H

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Veterans Benefits Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel

Non-VA Distribution

House Committee on Veterans' Affairs
House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/publications/reports-list.asp. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.