THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

April 12, 2023

The Honorable Henry Kerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, DC 20036

Re: Office of Special Counsel File No. DI-22-000594, DI-22-000637

Dear Mr. Kerner:

I am responding to your July 5, 2022, letter to the Department of Veterans Affairs (VA) regarding whistleblower allegations that employees at the VA Atlanta Healthcare System (hereafter, Atlanta) located in Atlanta, Georgia, may have engaged in conduct that may constitute a violation of law, rule or regulation; or created a substantial and specific danger to public health.

The Deputy Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health, directed the Office of the Medical Inspector to assemble and lead a VA team to investigate the allegations. We conducted an onsite investigation on this matter August 3, 2022, and a virtual investigation from August 30 – September 1, 2022.

We substantiate 1 of the whistleblowers' allegations and do not substantiate 10 allegations. We make 17 recommendations to Atlanta. The signed report will be sent to the respective offices with a request for an action plan.

Thank you for the opportunity to respond.

Sincerely,

Denis McDonough

Enclosure

DEPARTMENT OF VETERANS AFFAIRS

Washington, DC

Report to the
Office of Special Counsel
File Number DI-22-000594 and DI-22-000637

Atlanta Department of Veterans Affairs Medical Center
Atlanta, Georgia

Report Date: April 2023

CM: 2022-C-17

Executive Summary

The Deputy Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health, directed the Office of the Medical Inspector (OMI) to assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations submitted to the Office of Special Counsel (OSC) concerning the VA Atlanta Healthcare System (hereafter, Atlanta), located in Decatur, Georgia. Two Whistleblowers, both of whom consented to the release of their name, alleged employees engaged in conduct that may constitute a violation of a law, rule or regulation; or created a substantial and specific danger to public health. We conducted an unannounced onsite investigation at Atlanta on August 3, 2022, and conducted virtual interviews with employees from August 30 – September 1, 2022.

Specific Allegations of the Whistleblower

Whistleblower 1 provided 11 allegations for the investigation. Whistleblower 2 voiced three allegations, all of which were also provided by Whistleblower 1. The allegations that were provided by both Whistleblowers are noted. To guide the unannounced site visit, and to conduct the interviews required for the report, the allegations are grouped into four categories: Coronavirus 2019 (COVID-19); Environmental Cleaning and Disinfection; Water Temperature; and Nursing Practice.

COVID-19 Allegations

1. *IPU nursing staff are not provided with appropriate personal protective equipment, such as N-95 masks, for COVID-19 testing or to respond to a positive screen for COVID-19 in violation of VA Memorandum (VA Memo), Managing Operations of Mental Health Unit While Managing COVID-19, Attachment B "Guidance for VA Mental Health Residential Rehabilitation Treatment Programs." (This allegation voiced by both Whistleblowers.)*

2. *Veterans who test positive for COVID-19 are not transferred from a shared hospital room to another room after a positive test result, leading to additional exposure to COVID-19.*

3. *IPU leadership does not disclose when staff have been exposed to a Veteran who tested positive for COVID-19 in violation of the VA Memo, Attachment A "Guidance for VA Inpatient Mental Health Programs". Instead, staff must rely on word of mouth to discover they have been exposed to a Veteran who had tested positive.*

4. *Veterans spend most of their day in the Group Room where social distancing rules are not followed. Veterans are generally masked during this period, however when they eat meals, they are not masked and are not socially distanced." (This allegation voiced by both Whistleblowers.)*

5. *IPU staff does not perform screenings, including temperature checks, on Veterans and providers entering the unit in violation of the VA Memo.*

Environmental Cleaning and Disinfection Allegations

6. *After a Veteran who has tested positive for COVID-19 is transferred off the floor, IPU leadership does not require a "Terminal Cleaning" of the room – which is required following the stay of Veterans with other infectious diseases.*

7. *Unit surfaces that are repeatedly touched by staff and residents are not routinely or properly cleaned as required by the VA Memo.*

8. *There is dirt and grime on the floor and windows, mold and mildew in the patient shower, and insects are regularly found on the floors and walls of the unit (this allegation voiced by both Whistleblowers).*

Water Temperature Allegation

9. *Most sinks and showers in Veterans' rooms do not have hot water or are not functioning at all.*

Nursing Practice Allegations

10. *Nurses and other staff have been asked by leadership to violate the 1:1 monitoring policy outlined in VHA Handbook 1160.06, Inpatient Mental Health Services, dated September 16, 2013, and are often told to watch two Veterans at a time or monitor an entire floor instead of Veterans requiring 1:1 monitoring.*

11. *Inpatient Mental Health Program staff are being floated to the Emergency Department to perform COVID-19 testing in violation of the VA Memo.*

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place and **did not substantiate** allegations when the facts and findings showed the allegations were unfounded. We were **not able to substantiate** allegations when the available evidence was insufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of the findings, we make the following conclusions and recommendations.

Conclusions for Allegation 1

- We **do not substantiate** that Inpatient Psychiatric Unit (hereafter, 4Psych) Nursing staff are not provided with appropriate Personal Protective Equipment (PPE), such as N-95 masks, for COVID-19 testing or to respond to a positive screen for COVID-19 in violation of VA memorandum (VA Memo), Managing Operations of Mental Health Unit While Managing COVID-19, Attachment B "Guidance for VA Mental Health Residential Rehabilitation Treatment Programs," dated March 16, 2020.

- The staff on the unit do not routinely wear masks in violation of Atlanta Standard Operating Procedure (SOP), COVID-19 Infection Control Guidance which operationalizes Veterans Health Administration (VHA) Health Protection Levels at the facility.

- Communication about COVID-19 policies and procedures are readily available and provided to all employees from the Director via email, a newsletter and Microsoft Teams meetings. We found this to be a best practice.

- COVID-19 Health Protection levels and information about masks and other COVID-19 protection measures such as hand hygiene are clearly displayed at the entrance to the facility, are posted as signage throughout the facility and are included in the Director's newsletter communication, providing readily available information from various sources.

Recommendation to Atlanta

1. Provide remedial instruction for Mental Health staff on the facility Health Protection Levels and facility mask requirements and ensure adherence to the appropriate use of masks and other PPE as indicated. Establish a method to ensure compliance and consider disciplinary actions if needed.

Conclusions for Allegation 2

- We **do not substantiate** that Veterans who test positive for COVID-19 are not transferred from a shared hospital room to another room after a positive test result, leading to additional exposure to COVID-19.

- All Veterans admitted to the 4Psych unit are tested for COVID-19 prior to admission.

- Veterans who test positive for COVID-19 while admitted to 4Psych were appropriately and promptly transferred to the COVID-19 unit or appropriately discharged home with COVID-19 home and community care and isolations instructions.

- The census on the 4Psych unit during the pandemic was frequently low enough to allow for most Veterans to be admitted to a single room which potentially negated the need for transfer to a different room on 4Psych.

- Veterans on 4Psych who are not in a single room are appropriately isolated prior to transfer to the COVID-19 unit and their roommate is moved to a different room.

Recommendations to Atlanta

None.

Conclusions for Allegation 3

- We **do not substantiate** that 4Psych leadership does not disclose when staff have been exposed to a Veteran who tested positive for COVID-19 in violation of the VA Memo, Attachment A, "Guidance for VA Inpatient Mental Health Programs."

- Atlanta SOP Employee Occupational Health COVID-19 does not require unit leadership to disclose when staff have been exposed to a Veteran who tested positive. This exposure information is provided by Infection Control and Occupational Health services.

- We **do not substantiate** that staff must rely on word of mouth to discover they have been exposed to a Veteran who had tested positive. Employees are contacted by Infection Control and Occupational Health services to inform them of any exposure to Veterans who test positive.

- Employees are provided information about COVID-19 testing and Occupational Health in the Director's COVID-19 Weekly Update Newsletter.

- Information about Veterans who transfer to the COVID-19 unit is not consistently provided during change of shift report.

- Staff who provide care to positive Veterans while appropriately wearing PPE (such as masks) are not considered to be exposed.

Recommendations to Atlanta

2. Provide remedial education on Atlanta SOP Employee Occupational Health COVID-19 Standard Operating Procedure for all 4Psych staff.

3. Develop a comprehensive "Hand off Communication Tool" to be used during Change of Shift Report that includes safety information and clinical information about Veterans transferred due to a positive COVID-19 test. Include all staff in Change of Shift report and monitor for compliance.

Conclusions for Allegation 4

- We **substantiate** that Veterans spend most of their day in the Group Room where social distancing rules are not followed.

- Additionally, we **substantiate** that in general Veterans are masked in the Group Room; however, when they eat meals, they are neither masked nor socially distanced.

- Tables in the Group Room are appropriately distanced; however, Veterans can move chairs for socialization. Veterans are encouraged to wear masks in the Group Room.

- Enforcement of continuous wearing of masks in the inpatient mental health setting is challenging.

- Atlanta is appropriately using the maximum space available during mealtimes to implement the recommended physical distancing for inpatient dining.

Recommendation to Atlanta

4. Continue to review and utilize options available from the Office of Mental Health and Suicide Prevention SharePoint site related to social distancing and mask wearing to decrease risk of COVID-19 exposure and spread.

Conclusions for Allegation 5

- We **do not substantiate** that 4Psych staff do not perform screenings, including temperature checks, on Veterans and providers entering the unit in violation of the VA Memo.

- There is no requirement for 4Psych staff to perform screenings on Veterans or providers entering the unit.

- Atlanta follows the VHA Operational Plan and current Health Protection Level guidelines which allow self-screening for facility entry and does not require temperature checks.

Recommendations to Atlanta

None.

Conclusions for Allegation 6

- We **do not substantiate** that after a Veteran who has tested positive for COVID-19 is transferred off the floor, 4Psych leadership does not require a "Terminal Cleaning" of the room – which is required following the stay of Veterans with other infectious diseases.

- Nursing staff, not leadership, is responsible for contacting Environmental Management Services (EMS) staff via Bed Management Solution (BMS).

- Per EMS staff, rooms previously occupied by Veterans requiring isolation were not routinely identified as needing terminal cleaning in BMS requests.

- Equipment and chemical required for terminal cleaning of rooms for Veterans with infectious diseases are appropriate and available on the unit.

- The nursing staff lack understanding about the requirements for use of ultraviolet light for terminal cleaning, whereas there is no evidence to demonstrate EMS lacks this knowledge. EMS is responsible for this task regarding the use of the ultraviolet light.

- Immediately following the unannounced site visit a unit-based tiger team was identified to address environmental issues that were noted.

- Atlanta does not have a facility-wide EMS quality assurance plan.

Recommendations to Atlanta

5. Assess the BMS process for requesting terminal cleaning to ensure that nursing staff appropriately identify rooms occupied by Veterans requiring isolation. Provide training for nursing and EMS staff, if required.

6. The newly established tiger team will create and implement a process to ensure that work orders for environmental issues are appropriately entered, that concerns are followed to resolution, and that environmental issues are routinely monitored.

7. Review the current training program for EMS staff to ensure that consistent cleaning and disinfection processes are utilized in accordance with facility and Centers for Disease Control and Prevention (CDC) guidelines. Develop additional training as needed to meet facility and CDC disinfection requirements.

8. Consult the VHA Environmental Programs Service, Healthcare Environment and Facilities Programs to assist with developing an EMS focused quality assurance program.

Conclusions for Allegation 7

- We **do not substantiate** that unit surfaces that are repeatedly touched by staff and residents are not routinely or properly cleaned as required by the VA Memo.

- EMS staff appropriately clean high touch surfaces daily as required.

- Although non-EMS staff on the unit have been educated on the importance of cleaning, there is a reluctance by non-EMS staff to participate in maintaining the unit.

Recommendations to Atlanta

9. Re-educate non-EMS staff on the importance of cleaning high touch surfaces in nursing areas such as the nurse's station and medication room and non-clinical areas such as the staff break room.

10. Establish a method to encourage and monitor the cleaning of unit surfaces by non-EMS staff. Consider employee engagement strategies to foster a culture of cooperation and collaboration in maintaining a clean and healthy unit environment.

Conclusions for Allegation 8

- We **do not substantiate** that there is dirt and grime on the floor and windows, mold and mildew in the patient shower, and insects are regularly found on the floors and walls of the unit.

- Although there are dead insects between the safety Plexiglass and the exterior windows of the unit which are unsightly, the Plexiglass is an appropriate safety measure. Atlanta has a plan for cleaning of the windows including removal and replacement of the safety Plexiglass, a process that will include removal of the dead insects.

Recommendations to Atlanta

11. Ensure the planned window cleaning and Plexiglass replacement is completed as planned.

Conclusions for Allegation 9

- We **do not substantiate** the allegation that most sinks and showers in patient's rooms do not have hot water or are not functioning at all. We found that all patient rooms have functioning sinks and showers. However, there is a delay in the time it takes for hot water in the patient sinks and showers to reach a temperature that is comfortable for patient use.

- Atlanta is in compliance with VHA Directive 1061, Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems, with the highest water temperature in the shower found during testing to be 110 °F.

- The distance between the hot water source and absence of mixing valves at the patient sinks causes the hot water to feel cool when exiting the spout.

Recommendations to Atlanta

12. Continue routine monitoring of water temperature of patient showers and explore remediation options to provide up to the maximum warm water temperature of 110 °F in each patient shower on 4Psych.

13. Consider remediation options for patient sinks to provide warm water at the spout for hand washing.

Conclusions for Allegation 10

- We **do not substantiate** that nurses and other staff have been asked by leadership to violate the 1:1 monitoring policy outlined in VHA Handbook 1160.06 and are often told to watch two Veterans at a time or monitor and entire floor instead of Veterans requiring 1:1 monitoring.

- Nursing staff are appropriately rotated to other units to provide observation of patients when the workload and staffing mix on 4Psych is adequate.

- There is no evidence that rotating staff to other units has created a danger to patient safety on 4Psych.

- Although there was one reported incident of the inappropriate assignment of 4Psych staff to observe Veterans on another unit, the situation was immediately addressed by leadership. There have been no additional reports of inappropriate assignment on another unit.

Recommendation to Atlanta

14. Provide remedial education to nursing staff on 4Psych regarding rotation to other units to promote safety of Veterans requiring higher levels of observation and the expected compliance with rotation assignments.

Conclusions for Allegation 11

- We **do not substantiate** that Mental Health Program staff are being floated to the ED to perform COVID-19 testing in violation of the VA Memo.

- Based on review of the Nursing Hours Per Patient Day and the average daily census on the 4Psych unit, it is unlikely that rotation of staff to other units would have created a staffing shortage, or an unsafe nursing staff mix on the unit.

- Although Nursing staff on 4Psych were trained to perform nasal swabbing for COVID-19 testing, they refused their assignment to assist the ED during the COVID-19 pandemic.

Recommendation to Atlanta

15. Review the circumstances of the refusal of assignment by nursing staff and take administrative action, if appropriate.

Additional Conclusions

- The lack of permanent Nursing Leadership on 4Psych may have contributed to poor employee morale as evidenced by the All-Employee Survey results for fiscal year (FY) 2020 and FY 2021.

Recommendations to Atlanta

16. Actively recruit and hire nursing leadership positions for 4Psych including the Nurse Manager and three Assistant Nurse Managers.

17. Consult with an external office to conduct an assessment of the environment on 4Psych that has contributed to the poor morale and lack of cooperation among staff. Consider a consultation with the Office of the Chief Human Capital Officer and/or the National Center for Organization Development for workplace civility training to strengthen workforce engagement and employee satisfaction.

Summary Statement

We have developed this report in consultation with other VHA and VA offices to address OSC's concerns that employees engaged in conduct that may constitute a violation of a law, rule or regulation; engaged in gross mismanagement; or created a substantial and specific danger to public health. We reviewed the allegations and determined the merits of each, and the National Center for Ethics in Health Care has provided a health care ethics review. We substantiated an allegation related to social distancing on the unit for hospitalized psychiatric patients and a delay in the time it takes for hot water to arrive at the patient sinks and showers due to pipe and building structural work. We found no direct concerns causing a specific danger to public health.

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I. Introduction

The Deputy Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health, directed the Office of the Medical Inspector (OMI) to assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations submitted to the Office of Special Counsel (OSC) concerning the VA Atlanta Healthcare System (hereafter, Atlanta), located in Decatur, Georgia. Two Whistleblowers, both of whom consented to the release of their name, alleged employees engaged in conduct that may constitute a violation of a law, rule or regulation; or created a substantial and specific danger to public health. We conducted an unannounced onsite investigation at Atlanta on August 3, 2022, and conducted virtual interviews with employees from August 30, 2022 – September 1, 2022.

II. Facility Profile

Atlanta is part of the Veterans Integrated Service Network (VISN) 7, the VA Southeast Network. Atlanta, the largest facility in VISN 7, is classified as a Complexity Level 1a facility with 466 authorized inpatient beds: 273 medical/surgical beds, 120 Community Living Center beds, 61-bed Domiciliary and 12 Psychosocial Residential Rehabilitation Treatment Program beds.[1] Atlanta provides highly specialized care for Veterans including open heart surgery and cancer therapies. Comprehensive health care services are also provided through emergency medicine, primary care, tertiary care and long-term care in the areas of medicine, surgery, mental health, physical medicine and rehabilitation, neurology, oncology, podiatry, dentistry, geriatrics and extended care.

Atlanta has one Inpatient Psychiatric Unit on the fourth floor of the medical center. The Inpatient Psychiatric Unit (IPU) is known by staff as 4Psych. For the purposes of this report, 4Psych will be used to accurately refer to the IPU as opposed to "IPU" as referred to in the referral letter. The facility organization chart effective January 2022 shows the nursing staff on this unit includes 1 Nurse Manager, 3 Assistant Nurse Managers, 38 Registered Nurses (RN), 6 Licensed Practical Nurses (LPN) and 50 Nursing Assistants (NA)/Nurse Technicians. There are vacancies for the Nurse Manager and the three Assistant Nurse Managers, seven RNs and five NAs/Nursing Technicians. The interdisciplinary clinical team members on 4Psych include two Physician Assistants, seven Psychiatrists, two Psychologists, one Peer Support Specialist and one Recreation Therapist.

On August 26, 2022, the Veterans Health Administration (VHA) Novel Coronavirus Disease 2019 (COVID-19) National Data showed that Atlanta had 11,044 cumulative Veteran cases. Of those, 235 (or 2%) are known deaths. During the summer months of June, July and August 2022 Atlanta experienced a surge in COVID-19 cases. At the

[1] 1a-Highest complexity: Facilities with high-volume, high-risk patients, most complex clinical programs and large research and teaching programs.

time of the investigation, Atlanta had 183 active COVID-19 cases and had reported 2 employee deaths due to COVID-19 since the onset of the pandemic. [2, 3]

III. Specific Allegations of the Whistleblower

Whistleblower 1 provided 11 allegations for the investigation. Whistleblower 2 voiced three allegations, all of which were also provided by Whistleblower 1. The allegations that were provided by both Whistleblowers are noted. To guide the unannounced site visit, and to conduct the interviews required for the report, the allegations are grouped into four categories: COVID-19; Environmental Cleaning and Disinfection; Water Temperature; and Nursing Practice.

COVID-19 Allegations

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2. *Veterans who test positive for COVID-19 are not transferred from a shared hospital room to another room after a positive test result, leading to additional exposure to COVID-19.*

3. *IPU leadership does not disclose when staff have been exposed to a Veteran who tested positive for COVID-19 in violation of the VA Memo, Attachment A "Guidance for VA Inpatient Mental Health Programs". Instead, staff must rely on word of mouth to discover they have been exposed to a Veteran who had tested positive.*

4. *Veterans spend most of their day in the Group Room where social distancing rules are not followed. Veterans are generally masked during this period, however when they eat meals, they are not masked and are not socially distanced." (This allegation voiced by both Whistleblowers.)*

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[2] Department of Veterans Affairs COVID-19 National Summary. Accessed August 26, 2022. COVID-19 National Summary | Veterans Affairs (va.gov).

[3] Department of Veterans Affairs – Summary of VA Employee COVID-19 Related Deaths. Accessed August 26, 2022. COVID-19 VA Employee Deaths | Veterans Affairs.

7. *Unit surfaces that are repeatedly touched by staff and residents are not routinely or properly cleaned as required by the VA Memo.*

8. *There is dirt and grime on the floor and windows, mold and mildew in the patient shower, and insects are regularly found on the floors and walls of the unit. (This allegation voiced by both Whistleblowers.)*

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9. *Most sinks and showers in Veterans' rooms do not have hot water or are not functioning at all.*

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10. *Nurses and other staff have been asked by leadership to violate the 1:1 monitoring policy outlined in VHA Handbook 1160.06, Inpatient Mental Health Services, dated September 16, 2013, and are often told to watch two Veterans at a time or monitor an entire floor instead of Veterans requiring 1:1 monitoring.*

11. *Inpatient Mental Health Program staff are being floated to the Emergency Department to perform COVID-19 testing in violation of the VA Memo.*

IV. Conduct of Investigation

The VA team conducting the virtual investigation consisted of the Chief Senior Medical Investigator and a Clinical Program Manager, both from OMI; a Behavioral Health Chief Nurse, a Sanitation Program Manager from the VHA Office of Healthcare Environment and Facilities Programs and a Human Resources (HR)/Labor Relations Consultant from the Office of Workforce Management and Consulting.

We conducted entrance and exit briefings with the following Atlanta and VISN 7 leadership:

VISN 7 Leadership:

- Chief Medical Officer
- Chief Nursing Officer
- Chief Quality Management Officer
- Deputy Quality Management Officer
- Deputy Chief Mental Health

Atlanta Leadership:

- Director
- Deputy Director
- Associate Director
- Chief of Staff
- Deputy Chief of Staff
- Associate Director Nursing and Patient Care Services
- Deputy Associate Director Nursing and Patient Care Services
- Interim Chief, Quality Management
- Program Manager Quality Management

We interviewed the following Atlanta employees:

- Director
- Deputy Associate Director
- Chief of Staff
- Associate Director, Nursing/Patient Care Services
- Associate Chief of Staff, Mental Health Service Line
- Chief Nurse, Mental Health Nursing
- Deputy Chief of Staff
- Interim Chief, Quality Management
- Chief Nurse, Nursing Operations (Resources and Staffing)
- Deputy Chief, Office of Quality Management
- Chief, Occupational Health/Employee Health
- Risk Manager (Administrative Investigation Boards, Fact Findings, Institutional Disclosures)
- Risk Manager (Tort Claims)
- Interim Nurse Manager, 4Psych
- Clinical Psychologist, Clinical Director, Acute Mental Health Services
- Acting Associate Chief of Staff, Rehabilitation Service Line
- Program Manager, Infection Prevention and Control Program
- Chief, Environmental Management Services
- Housekeeping Aid
- Chief, Supply Chain Management
- Chief Engineer, Chief of Engineering Department
- Staff Psychologist, Deputy Chief, Mental Health Service Line
- Two NAs, 4Psych
- Two Staff Psychiatrists, Mental Health Service Line
- Two LPNs, 4Psych
- Two RNs, 4Psych

V. Background, Findings, Conclusions and Recommendations

COVID-19 Allegations

Background

Managing Inpatient Mental Health Operations during the COVID-19 Pandemic

On March 16, 2020, at the onset of the COVID-19 pandemic, the Deputy Under Secretary for Health for Operations and Management (DUSHOM) issued the Memorandum titled Managing Operations of Mental Health Unit While Managing COVID-19.[4] The memorandum included two attachments to guide local decision-making regarding admission to and operations of inpatient mental health units and residential treatment programs: Attachment A – Guidance for VA Inpatient Mental Health Programs and Attachment B – Guidance for VA Mental Health Residential Treatment Programs. Although the allegations provided by Whistleblower 1 cited Attachment B, because 4Psych is an inpatient mental health unit, not a Residential Rehabilitation Treatment Program, the guidance provided in Attachment B is not relevant to this investigation. Attachment A provides guidance for VA Inpatient Mental Health Programs and is appropriately related to the Whistleblower's allegations.

The DUSHOM Memorandum: Managing Operations of Mental Health Unit While Managing COVID-19 Attachment A states that the "guidance is intended to inform the development of local facility policy and procedures for prevention, screening, and surveillance of the [COVID-19] on Inpatient Mental Health Programs. Please refer to VHA COVID-19 Strategic Response Plan by VHA COVID-19 Workgroup Emergency Management Coordination Cell v1.0 released on March 3, 2020, for VHA department wide COVID-19 planning, including modifying responses based on the phase of the COVID-19 outbreak."[5] Attachment A further describes measures to prevent outbreaks of COVID-19 on inpatient mental health units. Measures include screening, surveillance, isolation, hand hygiene, sanitation and signage regarding hand hygiene, social distancing and stocking necessary Personal Protective Equipment (PPE) on the unit for contingency purposes.[6]

The Office of Mental Health and Suicide Prevention (OMHSP) maintains a SharePoint site that includes updated department COVID-19 guidance for inpatient mental health units.[7] OMHSP guidance includes two updates to the original March 2020 DUSHOM Memorandum referenced by Whistleblower 1. The updates were published on

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[4] Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum: Managing Operations of Mental Health Unit While Managing COVID-19. March 16, 2020. https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/Administration/DUSHOM%20Guidance/DUSHOM%20Memo%20dated%20031620%20subj%20Managing%20Operations%20of%20Mental%20Health%20Unit%20While%20Managing%20COVID-19.pdf.

[5] Ibid.

[6] Ibid.

[7] Inpatient Mental Health COVID-19 Guidance (sharepoint.com).

February 5, 2021, and July 29, 2021. The July 29, 2021, update "supersedes previous versions of Attachment A, Guidance for VA Inpatient Health Units."[8] The July 29, 2021, update states that "[f]acilities should follow updated guidance in the VHA Moving Forward Guidebook and consider local circumstances – such as COVID-19 prevalence, [PPE] supply and availability, testing, infection prevention and control, staffing and bed capacity – to inform local decision making regarding increasing or decreasing inpatient mental health beds."[9] The July 29, 2021, update further describes the importance of inpatient mental health unit staff working closely with facility Infectious Disease and Infection Prevention and Control staff in minimizing the impact of COVID-19 on the unit.[10]

Because the COVID-19 pandemic was and continues to be an evolving public health situation, the guidance used in this report to make recommendations to Atlanta will be guidance in effect at the time of the Whistleblower 1's disclosure in July 2022, unless that guidance has since been superseded by VHA policy or memorandum. The DUSHOM memorandum Attachment A referenced in the original Whistleblower 1 disclosure was not current guidance at the time the Whistleblower provided allegations to OSC and will not be used in this report to make recommendations.

Masks as a COVID-19 Prevention Strategy

The Centers for Disease Control and Prevention (CDC) website provides recommended strategies for preventing COVID-19 infection in health care settings including the "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" which outlines recommendations for facilities and health care workers such as current Infection Prevention and Control (IPC) recommendations, screening processes to enter a health care facility and the use of respirators or facemasks to prevent the spread of respiratory secretions.[11] On March 8, 2022, the VHA Assistant Under Secretary for Health for Operations published a Memorandum on masking and testing of staff in VHA's health care setting. The memorandum includes links to the CDC recommendations and provides consistent messaging throughout the agency in accordance with national CDC guidelines.[12]

CDC describes masking as a critical public health tool for preventing the spread of COVID-19 and recommends that all individuals wear the most protective mask that fits well and that can be worn consistently. Highly protective masks are important in high-

[8] Office of Mental Health and Suicide Prevention (VHA 11MHSP). Updated COVID-19 Guidance for VA Inpatient Mental Health Units July 2021 Update. 072921 Updated COVID19 Guidance for VA Inpatient MH Clean.pdf (sharepoint.com).
[9] Ibid.
[10] Ibid.
[11] Centers for Disease Control and Prevention. Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC.
[12] Department of Veterans Affairs Memorandum. Veterans Health Administration (VHA) Masking and Screening Testing Guidance for VHA staff in Healthcare Settings. March 8, 2022. 030822--Veterans Health Administration (VHA) Masking and Screening Testing Guidance for Healthcare Settings.pdf (sharepoint.com).

risk situations and are tested to ensure they perform at a consistent level. These masks meet standards developed by the National Institute of Occupational Safety and Health and are labeled to indicate that they meet a quality requirement.[13]

Medical face masks are classified based on the efficiency of the filtration the mask provides. The American Society for Testing and Materials (ASTM) has established a performance level for masks based on the percentage of filtration efficiency. Medical face masks (sometimes identified as a surgical mask) are designated as Level 1 barrier, Level 2 barrier and Level 3 barrier based on the performance properties of the materials used in the construction of the mask. A Level 1 mask is low barrier protection and is not used for aerosols, such as respiratory secretions. A level 2 mask provides moderate barrier protection and may be used in administrative locations, such as offices. A level 3 mask provides maximum barrier protection and can be used in situations with close contact or a high risk of aerosol exposure such as direct patient care. A medical face mask identified as a Level 3 is the most protective.[14] Respirators are different from, and are more protective than, medical face masks. Respirators, such as an N95 respirator has a tight seal around the face. Respirators may be used in any situation, but they are primarily used when caring for known infectious patients, such as those diagnosed with COVID-19. However, if an N95 respirator is not tightly fitted around the face, it is not fully effective. An N95 respirator is also useful and may provide additional protection when worn by persons who are not up to date with vaccinations.[15]

Guidance for the Transition from COVID-19 Pandemic to Endemic Operations

The VHA COVID-19 Operational Plan is "iterative guidance that provides the response framework and protocol for all VHA facilities to proactively navigate transition from pandemic to endemic COVID-19 operations." The VHA COVID-19 Operational Plan provides information and guidance in alignment with Federal partners including the CDC and is routinely updated based on current COVID-19 information. The VHA COVID-19 Operational Plan establishes a framework for a facility to continue to provide care to Veterans despite increases or decreases in COVID-19 conditions and evolving variants. The VHA COVID-19 Operational Plan is intended to prioritize Veteran and employee safety while empowering local leadership to make informed decisions to ensure Veterans receive timely, clinically appropriate care.[16] The VHA COVID-19 Operational plan provides general guidance and allows discretion for VISN and facility leadership to tailor the guidance to meet local circumstances. The VHA COVID-19 Operational Plan includes a color-coded guide (Figure 1, page 10) that assists facilities in developing local decisions for maximum access to safe, timely, high-quality care despite increases or decreases in COVID-19 conditions and evolving variants and helps to ensure Veteran and employee safety. Using the VHA COVID-19 Operational Plan, local leadership can implement protection levels at the facility based on the CDC level of

[13] Centers for Disease Control and Prevention. Types of Masks and Respirators. Masks and Respirators (cdc.gov).
[14] ASTM International Designation: F2100-21. Standard Specification of Performance of Materials Used in Medical Face Masks. ASTM International - Standards Worldwide.
[15] Centers for Disease Control and Prevention. Types of Masks and Respirators. Masks and Respirators (cdc.gov).
[16] VHA COVID-19 Operational Plan. VHA High Consequence Infection (HCI) Preparedness Program (sharepoint.com).

community transmission.[17] Protection levels are determined by the number of new cases per 100,000 persons and positive Nuclear Acid Amplification Test (see below).[18]

VHA COVID-19 Operational Plan
COVID-19 Health Protection Levels[19]

	VHA	Low	Medium	High
		↑	↑	↑
	CDC	Low	Moderate	Substantial	High
Indicators	New cases per 100,000 persons in the past 7 days	<10	10-49.99	50-99.99	≥100
Indicators	Percentage of positive NAAT tests during past 7 days	<5%	5-7.99%	8-9.99%	≥10.0%

Figure 1. VHA COVID-19 Operational Plan. COVID-19 Health Protection Levels

Allegation 1

4Psych nursing staff are not provided with appropriate personal protective equipment, such as N-95 masks, for COVID-19 testing or to respond to a positive screen for COVID-19 in violation of VA memorandum (VA Memo), Managing Operations of Mental Health Unit While Managing COVID-19, Attachment B "Guidance for VA Mental Health Residential Rehabilitation Treatment Programs." (This allegation was voiced by both Whistleblowers.)

Findings

The Atlanta Standard Operating Procedure (SOP) COVID-19 Infection Control Guidance establishes procedures and processes to ensure compliance with CDC and VA guidelines to prevent and control the spread of COVID-19 in the Atlanta VA Medical Center (VAMC).[20] The SOP describes and implements the VHA Health Protection

[17] Ibid.
[18] A Nucleic Acid Amplification Test, or NAAT, is a type of viral diagnostic test for SARS-CoV-2, the virus that causes COVID-19. NAATs detect genetic material (nucleic acids). (https://www.cdc.gov/coronavirus/2019-ncov/lab/naats.html) Last updated June 16, 2021.

[19] Ibid.
[20] Atlanta VA Medical Center Standard Operating Procedure (SOP). COVID-19 Infection Control Guidance (rev 08.22). Effective date August 12, 2022.

Levels and associated processes as outlined in the previously discussed VHA Operational Plan.

When we entered the facility on August 3, 2022, we observed signage at the entrance indicating that the Atlanta COVID-19 Protection Level was HIGH. An employee was stationed at the entrance to ensure all persons entering the facility were wearing masks and masks were provided if needed. We observed visual alerts such as the 'speedometer style' meter (Figure 2) to alert employees and visitors of the Health Protection Level and other signs with instructions to properly wear a face mask and perform hand hygiene. The visual cues and other requirements are in accordance with the VHA COVID-19 Operational Guidance for a HIGH Protection Level (Attachment B).

Figure 2. VHA Protection Level. Atlanta VA Health Care System August 3, 2022

We met with the Director to announce our arrival. During the meeting we learned that the Director publishes a COVID-19 Weekly Update Newsletter describing the current Health Protection Level for Atlanta and reinforcing the protection requirements. The newsletter is developed by members of the COVID-19 Incident Command, which includes representatives from Occupational Health, Infection Control and Infectious Disease and Medicine. The newsletter is coordinated for publication by Public Affairs and the Executive Leadership Team at Atlanta to ensure clarity of clinical information and readability and to ensure the newsletter is updated and aligned with VHA guidance for compliance.

All Atlanta employees receive a weekly email from the Director. The Director's email includes the Director's COVID-19 Weekly Update Newsletter and may also include other pertinent information. For example, on July 27, 2022, the Director's email included the Employee Occupational Health COVID-19 SOP.[21] The day of our unannounced arrival, August 3, 2022, the Director sent the 201st edition of the COVID-19 Weekly Update Newsletter to employees. Topics in the Director's newsletter include information about vaccines, boosters, reminders about proper masking and employee testing for COVID-19. The newsletter also includes links to local policies, employee health and VHA policy and guidance. The newsletter includes a schedule for the twice per month

[21] Atlanta VA Medical Center. Employee Occupational Health COVID-19 Standard Operating Procedure. March 2, 2022.

"Fireside Chats" with employees that are conducted live from the Director's office using Microsoft Teams.

Immediately after greeting the Director, we proceeded to the 4Psych unit. When we entered the unit, we observed four staff in the nurses' station, three of whom were wearing masks and one was not wearing a mask. We observed other staff in the hallways and patient care areas such as the Group Room who were not wearing masks. We also observed staff not wearing their masks properly, for example masks were worn below the nose or under the chin. The lack of mask wearing is in violation of Atlanta SOP, COVID-19 Infection Control Guidance.[22] As our tour of the unit progressed, we observed staff putting on masks and wearing them properly.

When we toured the nurses' station we found a supply of masks on a desk, readily available for all staff. We observed two full boxes of Level 2 masks and a partially full box of Level 3 masks. We provided immediate educational information and told the staff that a Level 3 mask or higher is the best barrier protection for situations with close contact or a high risk of aerosol exposure such as direct patient care on an inpatient unit. The staff called the supply technician who brought an additional supply (boxes) of Level 3 masks to the unit in less than 20 minutes. The supply technician also removed the level 2 masks from the nurses' station and the supply closet and placed a supply of Level 3 masks in the supply closet. We also inspected the supply closet and found a supply of N95 masks available for staff use.

When we toured the provider workspace offices, we observed five providers, all of whom were wearing Level 2 masks in the office space. We provided instruction about the use of Level 3 masks for direct patient care and the providers opened the cabinet in the office to display a supply of Level 3 and N95 masks readily available for use. The providers also told us that they were able to provide masks to any staff member who requested a mask from their supply cabinet.

We were told by both Whistleblowers that at the beginning of the pandemic, there was a shortage of masks, but that masks are currently available with no shortage. We were also told this same information by all other staff we interviewed.

Conclusions for Allegation 1

- We **do not substantiate** that 4Psych Nursing staff are not provided with appropriate PPE, such as N95 masks, for COVID-19 testing or to respond to a positive screen for COVID-19 in violation of VA memorandum (VA Memo), Managing Operations of Mental Health Unit While Managing COVID-19, Attachment B "Guidance for VA Mental Health Residential Rehabilitation Treatment Programs," dated March 16, 2020.

[22] Ibid.

- The staff on the unit do not routinely wear masks in violation of Atlanta SOP, COVID-19 Infection Control Guidance, which operationalizes VHA Health Protection Levels at the facility.

- Communication about COVID-19 policies and procedures is readily available and provided to all employees from the Director by email, a newsletter and Microsoft Teams meetings. We found this to be a best practice.

- COVID-19 Health Protection levels and information about masks and other

  COVID-19 protection measures such as hand hygiene are clearly displayed at the entrance to the facility, are posted as signage throughout the facility and are included in the Director's newsletter communication, providing readily available information from various sources.

Recommendation to Atlanta

1. Provide remedial instruction for Mental Health staff on the facility Health Protection Levels and facility mask requirements and ensure adherence to the appropriate use of masks and other PPE as indicated. Establish a method to ensure compliance and consider disciplinary actions if needed.

Allegation 2

Veterans who test positive for COVID-19 are not transferred from a shared hospital room to another room after a positive test result, leading to additional exposure to COVID-19.

Findings

The current Atlanta SOP, COVID-19 Testing Guidance, provides instruction for screening and testing of Veterans prior to admission.[23] This SOP was previously published on December 10, 2021, and updated on May 13, 2022. The procedures for screening and testing Veterans for admission to a non-COVID-19 unit remained the same with the revision of the SOP. All Veterans admitted to a non-COVID-19 inpatient setting are required to have a negative COVID-19 test to facilitate admission. According to the SOP, Atlanta uses the BinaxNOW Rapid COVID-19 Test™ which provides results in 15 minutes.[24] A Veteran with a negative BinaxNOW test can be admitted to a non-COVID-19 unit. Because a negative rapid test does not rule out infection for a person without symptoms, a confirmatory Polymerase Chain Reaction (PCR) test is performed upon admission. The PCR test is evaluated in a laboratory and can detect viral genetic material in persons who do not have symptoms. Although PCR test results are often

[23] Atlanta VA Medical Center Standard Operating Procedure. *COVID-19 Testing Guidance.* May 13, 2022.
[24] BinaxNOW Rapid COVID-19 test is an FDA-approved test for COVID-19 that provides results in 15 minutes. The test requires a lower nostril nasal swab to check for the presence of absence of proteins from the virus that causes COVID-19. BinaxNOW COVID-19 Ag 2 Card - Healthcare Provider Fact Sheet (fda.gov).

available the next day, it is not unusual for it to take up to 3 days for the results to be available.

After admission to 4Psych with the negative BinaxNOW™ test, all Veterans are screened daily for COVID-19 symptoms using screening questions and vital signs. Screening questions are documented in the Electronic Health Record (EHR). If a PCR test result is found by the laboratory to be positive, this is documented in the EHR and a provider on the unit is notified immediately. A positive PCR test result requires the transfer of the Veteran to the COVID-19 unit. We learned that Veterans with mental health needs who are transferred to the COVID-19 unit for medical care continue to receive mental health care while on the COVID-19 unit.

4Psych is a 40-bed inpatient unit consisting of two main hallways, (an East and a West side). There are 25 patient rooms, with 10 being single occupancy and 15 rooms double occupancy. If all beds are occupied, the maximum number of inpatient Veterans on the unit is 40.

To determine if the average daily census on 4Psych allows for Veterans to be admitted to single occupancy rooms, we reviewed the average daily census during the COVID-19 pandemic. (Figure 3) We found that the census from October 2020 through July 2022 was typically low enough for most Veterans to be admitted to a single room. All Veterans, including those who are admitted to a shared room, are screened and tested prior to admission according to facility policy. Leadership told us that in accordance with OMHSP guidance, although single occupancy is preferred, Veterans are not denied care due to the lack of availability of a single room.[25]

[25] Office of Mental Health and Suicide Prevention (VHA 11MHSP). Updated COVID-19 Guidance for VA Inpatient Mental Health Units July 2021 Update. 072921 Updated COVID19 Guidance for VA Inpatient MH Clean.pdf (sharepoint.com).

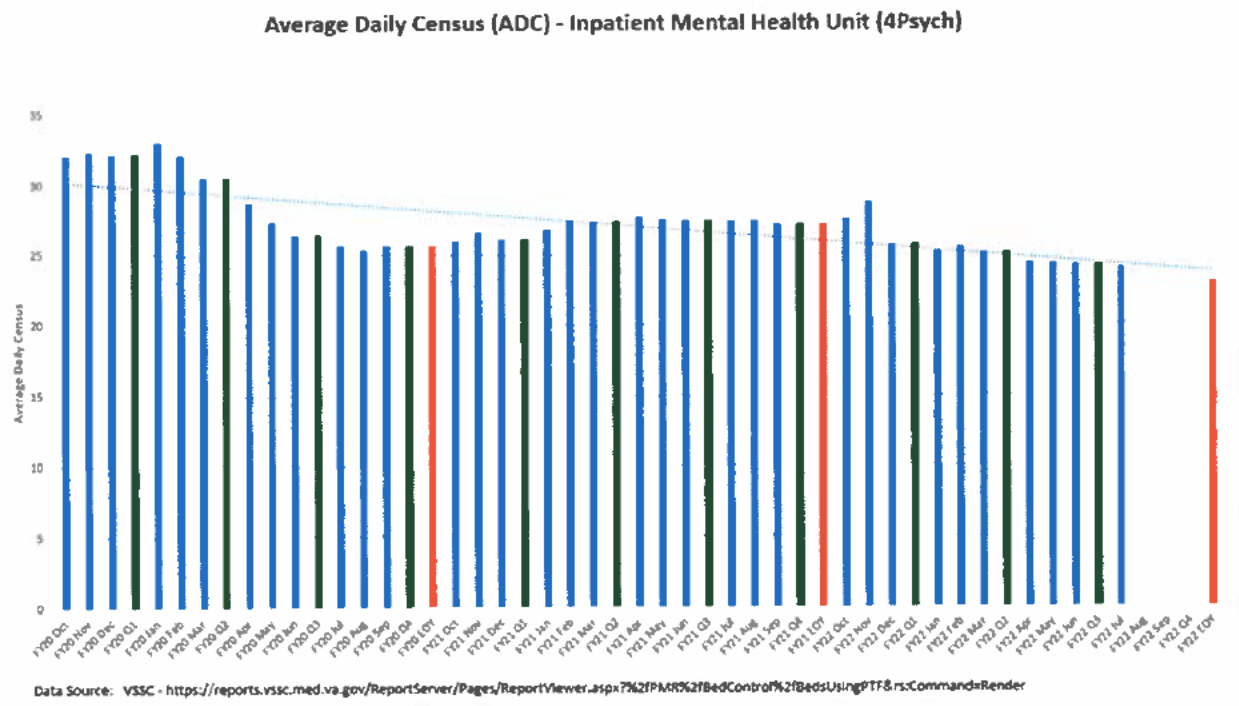

Figure 3. Average Daily Census 4Psych. October 2020 through July 2022

We were told by Infection Control leadership that if any Veteran on 4Psych in a shared room is found to be positive through routine screening or testing, the roommate is immediately moved to a single room and the Veteran who tested positive is isolated in their original room until they are transferred to the COVID-19 unit. Per facility policy, the Veteran with suspected or confirmed COVID-19 is required to be in a single room with the door closed and a single bathroom until they can be admitted to the COVID-19 unit.[26]

Whistleblower 1 provided the names of nine Veterans who tested positive for COVID-19 after being admitted to the 4Psych unit. We reviewed the EHR for these Veterans and found that eight of the nine Veterans entered the facility through the emergency room where they were tested for COVID-19 in accordance with facility guidelines outlined in Atlanta SOP, COVID-19 Testing Guidance, and in accordance with CDC recommendations and were found to be initially negative for COVID-19.[27, 28] One Veteran was admitted to 4Psych from a community hospital; the Veteran was confirmed to have a negative PCR test prior to admission to Atlanta.

Of the nine Veterans, we found that three (or 33%) were documented to be admitted to a single room and one Veteran (or 11%) who was documented in nursing notes to be

[26] Atlanta VA Medical Center SOP. *COVID-19 Infection Control Guidance*. March 7, 2022.
[27] Atlanta VA Medical Center SOP. *COVID-19 Testing Guidance*. December 10, 2021. Revised May 13, 2022.
[28] Centers for Disease Control. Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC.

isolated in his room prior to transfer to the COVID-19 unit. Of the remaining five Veterans (or 56%) there is no evidence in the EHR to determine if the Veterans were admitted to single or shared rooms. Infection Control leadership confirmed that in a roommate situation on any unit when a Veteran tests positive for COVID-19, the positive Veteran is isolated in the room until transfer; the roommate is moved to another room and is tested for COVID-19. The isolation of the COVID-19 positive Veteran in a single room, or alone in a shared room, minimizes the risk of further exposure to other Veterans. Infection Control leadership confirmed that staff appropriately wearing masks are not considered exposed.

Seven of the nine (or 78%) Veterans who were found to be positive during their inpatient stay were promptly and appropriately transferred to the COVID-19 unit during the shift when they were found to be COVID-19 positive. Six of these seven (or 86%) Veterans were transferred within 3 hours of the positive COVID-19 test results; the other Veteran was isolated in his room and was receiving intravenous medication (remdesivir) while awaiting transfer later in the same shift. These seven Veterans continued to receive documented mental health care while on the COVID-19 unit. Two Veterans were found to be positive on the day of their scheduled discharge from 4Psych; they were appropriately discharged with COVID-19 home and community care and isolation instructions.

Conclusions for Allegation 2

- We **do not substantiate** that Veterans who test positive for COVID-19 are not transferred from a shared hospital room to another room after a positive test result, leading to additional exposure to COVID-19.

- All Veterans admitted to the 4Psych unit are tested for COVID-19 prior to admission.

- Veterans who test positive for COVID-19 while admitted to 4Psych were appropriately and promptly transferred to the COVID-19 unit or appropriately discharged home with COVID-19 home and community care and isolations instructions.

- The census on the 4Psych unit during the pandemic was frequently low enough to allow for most Veterans to be admitted to a single room which potentially negated the need for transfer to a different room on 4Psych.

- Veterans on 4Psych who are not in a single room are appropriately isolated prior to transfer to the COVID-19 unit and their roommate is moved to a different room.

Recommendations to Atlanta

None.

Allegation 3

4Psych leadership does not disclose when staff have been exposed to a Veteran who tested positive for COVID-19 in violation of the VA Memo, Attachment A, "Guidance for VA Inpatient Mental Health Programs." Instead, staff must rely on word of mouth to discover they have been exposed to a Veteran who had tested positive.

Findings

At Atlanta, Infection Control and Occupational Health work in tandem to review potential exposure of employees to COVID-19 in the workplace.

Per Infection Control leadership, a high-risk exposure to a Veteran who tests COVID-19 positive is defined as 15 minutes of contact within 6 feet of the Veteran without wearing PPE. Staff who provide care to positive Veterans while appropriately wearing PPE (such as masks) are not considered to be exposed.

Atlanta SOP, Employee Occupational Health COVID-19, establishes process and procedures on prevention and controlling the transmission of employee COVID-19 infections. Employees with an exposure to a person with a positive COVID-19 infection or an employee with COVID-19 symptoms are provided work guidance and work restrictions.[29] Per the SOP, when a Veteran on a non-COVID-19 unit tests positive, Infection Control staff receive notification about the COVID-19 positive Veteran through a communication system that includes laboratory reports, Occupational Health reports and internal electronic documentation notifications. Infection Control also receives information about employees who test positive for COVID-19. Infection Control is responsible for identifying employees with potential high-risk exposure to a COVID-19 positive Veteran or employee. Employees with potential high-risk exposure are requested to complete an online Occupational Health Employee Exposure Questionnaire. Occupational Health reviews the questionnaire and contacts the employee by phone or email to provide guidance and testing recommendations. Employees can also call Occupational Health to discuss the exposure. COVID-19 testing is offered to employees, if indicated. Employees are responsible for providing home or mobile contact information to Occupational Health if they want to be contacted for screening or testing while off duty. Per the policy, staff in close contact to a person with documented COVID-19 infection while using recommended personal protective equipment are not considered exposed and do not need to be tested.[30]

Per facility policy, there is no responsibility assigned to Psychiatric leadership to disclose when staff have potentially been exposed to a Veteran who has tested positive. The responsibility to identify employees with defined close contact is a function of Infection Control and Occupational Health.[31]

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[29] Atlanta VA Medical Center SOP *Employee Occupational Health COVID-19 Standard Operating Procedure*, March 2, 2022.
[30] Ibid.
[31] Ibid.

The process for identifying COVID-19 positive Veterans and employees was described to us by leadership. However, staff interviewed were not clear on the notification and testing process for employees. As previously discussed, information about employee testing and Occupational Health are routinely provided in the Director's weekly email and COVID-19 Weekly Update Newsletter, as discussed in "Findings" for Allegation 1. Although we found no policy requirement for word-of-mouth communication, we were told by 4Psych staff that they would prefer to hear about Veterans who were transferred to the COVID-19 unit at change of shift report; however, the information is not shared consistently with all staff. We were told that when some nurses are in charge, Health Technicians are excluded from change of shift report. We found no change of shift reporting sheet for standard communication and no requirement for inclusion or attendance of all staff at change of shift report.

Conclusions for Allegation 3

- We **do not substantiate** that 4Psych leadership does not disclose when staff have been exposed to a Veteran who tested positive for COVID-19 in violation of the VA Memo, Attachment A, "Guidance for VA Inpatient Mental Health Programs." Additionally, **we do not substantiate** that staff must rely on word of mouth to discover they have been exposed to a Veteran who had tested positive.

- Atlanta SOP Employee Occupational Health COVID-19 does not require unit leadership to disclose when staff have been exposed to a Veteran who tested positive. This exposure information is provided by Infection Control and Occupational Health services.

- There is no evidence that staff must rely on word of mouth to determine exposure to a Veteran who tested positive. Employees are contacted by Infection Control and Occupational Health services to inform them of any exposure to Veterans who test positive.

- Employees are provided information about COVID-19 testing and Occupational Health in the Director's COVID-19 Weekly Update Newsletter.

- Information about Veterans who transfer to the COVID-19 unit is not consistently provided during change of shift report.

- Staff who provide care to positive Veterans while appropriately wearing PPE (such as masks) are not considered to be exposed.

Recommendations to Atlanta

2. Provide remedial education on Atlanta's Employee Occupational Health COVID-19 Standard Operating Procedure for all 4Psych staff.

3. Develop a comprehensive "Hand off Communication Tool" to be used during Change of Shift Report that includes safety information and clinical information about

Veterans transferred due to a positive COVID-19 test. Include all staff in Change of Shift report and monitor for compliance.

Allegation 4

Veterans spend most of their day in the Group Room where social distancing rules are not followed. Veterans are generally masked during this period, however when they eat meals, they are not masked and are not socially distanced. (This allegation was voiced by both Whistleblowers.)

Findings

When we arrived on the unit, we observed four Veterans sitting at a table in the Group Room; these Veterans were not masked or socially distanced. During the tour of the unit, we also observed Veterans in their room and walking in the hallway, some of whom were masked, others were not masked or not wearing masks correctly. Masks for Veteran use are available in the nurse's station and are routinely provided. There are two Group Rooms on the unit. The tables in the Group Rooms are appropriately distanced, however, the chairs are easily moved allowing Veterans to sit together for socialization. There are signs posted in the Group Room encouraging Veterans to wear masks. Due to the inpatient mental health needs of the Veterans, it is challenging to enforce mask wearing at all times.

OMHSP maintains a SharePoint site that includes department COVID-19 guidance for Inpatient Mental Health Units. Accessible on the SharePoint site is the Updated COVID-19 Guidance for VA Inpatient Mental Health Units July 29, 2021.[32] The updated COVID-19 guidance includes specific procedures for physical distancing on inpatient units. The procedures include limiting social activities that bring together groups of patients and use of virtual options to support maximum safety. We learned that these options are used at Atlanta during group therapy sessions. In addition, the low patient census previously discussed supports physical distancing efforts.

Physical distancing strategies are also recommended during dining. Veterans naturally need to remove masks for dining. Recommended strategies to assist with physical distancing while dining include staggering mealtimes and expanding the locations in which Veterans may eat. The updated guidance also includes discussion of staff physical distancing during break and mealtimes such as staggering break times if the staff break room is small to minimize potential exposure when eating without a mask.[33]

As stated above, there are two Group Rooms on the 4Psych unit. The census was less than 40 patients for the duration of the pandemic. Although it may be possible to use one Group Room for dining with a low census, we learned that since the beginning of the pandemic, both Group Rooms are consistently used for dining to promote

[32] Office of Mental Health and Suicide Prevention (VHA 11MHSP). Updated COVID-19 Guidance for VA Inpatient Mental Health Units July 2021 Update. 072921 Updated COVID19 Guidance for VA Inpatient MH Clean.pdf (sharepoint.com).
[33] Ibid.

distancing. We were told by two mental health providers that Atlanta also attempted staggered dining times; however, this was not a successful social distancing strategy as Veterans who were not on the "first dining shift" were displeased with the need to wait for their mealtime. Because the staggered mealtimes caused undue stressors for Veterans and staff, this strategy was discontinued.

Conclusions for Allegation 4

- We **substantiate** that Veterans spend most of their day in the Group Room where social distancing rules are not followed.
- Additionally, we **substantiate** that in general Veterans are masked in the Group Room; however, when they eat meals (without masks) they are not socially distanced.
- Tables in the Group Room are appropriately distanced; however, Veterans can move chairs for socialization. Veterans are encouraged to wear masks in the Group Room.
- Enforcing continuous mask wearing in the inpatient mental health setting is challenging.
- Atlanta is appropriately using the maximum space available during mealtimes to implement the recommended physical distancing for inpatient dining.

Recommendations to Atlanta

4. Continue to review and utilize options available from the OMHSP SharePoint site related to social distancing and mask wearing to decrease risk of COVID-19 exposure and spread.

Allegation 5

4Psych staff does not perform screenings, including temperature checks, on Veterans and providers entering the unit in violation of the VA Memo.

Findings

The aforementioned updated COVID-19 Guidance for VA Inpatient Mental Health Units found on OMHSP's SharePoint states that all inpatient mental health units should adhere to the most recent VHA screening and testing process in accordance with local policy.[34] Atlanta follows the VHA COVID-19 Operational Plan to operationalize facility entry screenings and temperature checks. The VHA Operational Plan is developed in accordance with Federal partners including the CDC and Occupational Safety and Health administration (OSHA) and is found on the internal VHA High Consequence

[34] Ibid.

Infection (HCI) Preparedness Program SharePoint site.[35] At the time of the OMI site visit, the Atlanta COVID-19 Protection Level was HIGH. When the Protection Level is HIGH, entry to the facility requires visitors and staff to perform a self-assessment, known as passive screening, to determine COVID-19 status or potential for infection. Temperature checks are not required for entry to the facility. The VHA Protection Level for Atlanta and information about the associated passive screening requirement at the entrance is also found in the weekly Director's COVID-19 Weekly Update.

We found no evidence of any requirement or policy/guidance, nor did anyone interviewed state, that 4Psych staff must perform screenings and temperature checks on Veterans or providers entering the unit. Veterans are screened in the ED prior to admission to the unit. Providers are screened at the facility entrance in accordance with the VHA COVID-19 Operational Plan.

Conclusions for Allegation 5

- We **do not substantiate** that 4Psych staff do not perform screenings, including temperature checks, on Veterans and providers entering the unit in violation of the VA Memo.
- There is no requirement for 4Psych staff to perform screenings on Veterans or providers entering the unit.
- Atlanta follows the VHA Operational Plan and current Health Protection Level guidelines which allow self-screening for facility entry and does not require temperature checks.

Recommendations to Atlanta

None.

Environmental Cleaning and Disinfection Allegations

Background

At the onset of the COVID-19 pandemic in January 2020, VHA established cleaning guidelines for medical equipment and guidelines for the cleaning of the environment when caring for Veterans with known or suspected COVID-19. The cleaning guidelines are part of the aforementioned COVID-19 Operational Plan that is routinely updated based on current COVID-19 information. As discussed, the VHA COVID-19 Operational Plan is in alignment with Federal partners and is found on the internal VHA HCI site.[36]

The VHA COVID-19 Operational Plan includes the Healthcare and Environment Facilities Programs (HEFP) COVID-19 Cleaning and Disinfection matrix that describes

[35] VHA COVID-19 Operational Plan. VHA High Consequence Infection (HCI) Preparedness Program (sharepoint.com).
[36] Ibid.

cleaning requirements for single and semi-private patient rooms when a confirmed or suspected COVID-19 positive Veteran is discharged. The matrix also provides information for cleaning non-COVID-19 rooms and instruction for cleaning public areas in the facility to prevent the spread of COVID-19. The Cleaning and Disinfection Matrix specifies that the cleaning and disinfection is a 2-step process.[37]

Cleaning, the first step of the 2-step process, is accomplished manually using water with a detergent agent to remove visible dirt and soil from a surface or object. Cleaning is necessary before disinfection because material that remains on a surface interferes with the effectiveness of disinfection. Disinfection, the second step of the 2-step process, eliminates pathogenic microorganisms (germs) on a surface. In health care, surfaces are disinfected using liquid chemicals. The chemicals are allowed to dry completely to provide disinfection. Ultraviolet radiation may be used in the health care environment as a supplement for the destruction of airborne organisms or inactivation of microorganisms on surfaces. However, the use of ultraviolet light is not routinely required; the germicidal effectiveness of ultraviolet light is influenced by numerous factors including the type of organism and the intensity from the ultraviolet lamps.[38]

VHA Directive 1850, Environmental Programs Service (EPS), establishes the policy and responsibilities for providing oversight and operational guidance to the Environmental Management Services (EMS) and other health care environmental program functions at VA medical facilities.[39] EPS' responsibilities include oversight of the Integrated Pest Management Program (IPM) which provides the requirement for establishing and maintaining an effective IPM program within VA medical facilities, and the Healthcare Environmental Services Program that outlines the procedures and operating guidelines pertaining to sanitation within VA medical facilities including, but not limited to, cleaning and infection control.[40]

EPS publishes an EPS Sanitation Procedure Guide that is available to managers and employees as electronic media.[41] The Sanitation Procedure Guide provides information and guidelines for use by the facility in collaboration with facility infection control practitioners and facility EMS leadership. The EPS Sanitation Procedure Guide follows guidelines in accordance with CDC recommendations for cleaning all areas of the facility including patient rooms with isolation precautions to prevent the transmission of infectious agents. A Veteran determined to be positive for COVID-19 is placed in isolation or the designated COVID-19 unit and the room is cleaned as an isolation room. When a Veteran is discharged, the room is cleaned using a 2-step process for terminal cleaning. The term 'terminal cleaning' is used interchangeably with the term 'terminal/discharge' cleaning. When a Veteran is discharged, the Sanitation Procedure Guide clearly outlines the 2-step process for terminal cleaning of an isolation room and

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[37] Ibid.
[38] Centers for Disease Control (CDC). Guideline for Disinfection and Sterilization in Healthcare Facilities. Disinfection & Sterilization Guidelines | Guidelines Library | Infection Control | CDC.
[39] VHA Directive 1850. *Environmental Programs Service*. March 31, 2017.
[40] Ibid.
[41] Environmental Programs Service (EPS) Sanitation Procedure Guide. August 5, 2021. EPS Sanitation Procedure Guide | Healthcare Environment and Facilities Programs (va.gov).

provides information on the correct chemical disinfectant to be used if the room was an isolation room was because of COVID-19.[42]

VHA Directive 1131(5), Management of Infectious Diseases and Infection Prevention and Control Programs, establishes requirements in VA medical facilities for management of infection diseases.[43] VHA Directive 1131(5) describes the methods required for daily cleaning of high touch surfaces and describes the aforementioned 2-step process for terminal/discharge cleaning of patient rooms as found in the EPS Sanitation Procedure Guide. VHA Directive 1131(5) states that ultraviolet light may be used as an adjunct for disinfection after the 2-step cleaning process has been completed in accordance with EPS procedures. In accordance with VHA Directive 1131(5), the Atlanta SOP COVID-19 Infection Control Guidance establishes processes and procedures to ensure compliance with CDC and VA guidelines. The Atlanta SOP uses the VHA COVID-19 Operational Plan as a guide to prevent and control the spread of COVID-19.[44]

When a Veteran is discharged, staff request terminal/discharge cleaning from EMS using the Bed Management Solution (BMS), a real-time Web-based interface for tracking patient movement. Using BMS is mandated by VHA Directive 1002, Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities.[45] Using BMS ensures effective bed management when patients are admitted, transferred or discharged. VHA Directive 1002 requires that BMS is used by all clinical and administrative staff in appropriate departments including the bed flow or transfer coordinator, unit clerks, nursing staff and environmental management staff.[46]

EPS provides oversight for pest management at VA medical facilities. VHA Directive 1850.02, Pest Management Operations Program, requires that each VA medical facility establish and maintain an IPM program.[47] The purpose of IPM is to prevent or control disease vectors and other pests that may adversely affect health. The IPM is a decision-making process that considers cultural, mechanical, biological and chemical controls of pests such as insects or other pests. "Where chemical control is indicated, specific pest populations are targeted for treatment when they are most vulnerable rather than a general application. Using appropriate control measures and proper application, IPM can result in a reduction in the use of pesticides, which may adversely impact human health and the environment."[48] VHA Directive 1850.02 identifies the potentially serious adverse effect of pesticide exposure on patients and addresses safety considerations when choosing a method to address pest issues. Using alternative control methods

[42] Ibid.
[43] VHA Directive 1131(5) Management of Infectious Diseases and Infection Prevention and Control Programs. November 7, 2017. Amended June 4, 2021.
[44] Atlanta VA Medical Center Standard Operating Procedure COVID-19 Infection Control Guidance. August 12, 2022.
[45] VHA Directive 1002. Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities. November 28, 2017.
[46] Ibid.
[47] VHA Directive 1850.02. Pest Management Operations. April 6, 2017.
[48] Ibid.

such as environmental sanitation and trapping are identified as a first choice with the use of pesticides to be considered after the failure of other methods of pest control.[49]

Allegation 6

After a Veteran who has tested positive for COVID-19 is transferred off the floor, 4Psych leadership does not require a "Terminal Cleaning" of the room – which is required following the stay of Veterans with other infectious diseases.

Findings

During our unannounced site visit we observed two rooms that had been terminally cleaned. One of the rooms appeared appropriately clean. In the other room we found specks of black debris on the fresh bed linens. We observed that the black debris was coming from the overhead vent system. We found no evidence of a work order entry related to this problem.

We learned that immediately after the site visit, the facility established an action plan specific to 4Psych that includes developing a unit-based team (tiger team) tasked to ensure that work orders for environmental issues are appropriately entered and that concerns are followed to resolution. Prior to the development of the tiger team, Atlanta did not have a process or a specific program related to EMS quality assurance to ensure completion of work orders or monitoring of environmental issues. Although Atlanta is developing this unit-based team (tiger team), Atlanta does not have a facility-wide EMS quality assurance plan.

Because it is not possible to determine by observation alone if rooms have been cleaned using the required 2-step process, we reviewed the Atlanta Sanitation Procedures Guide and found that the facility guide includes appropriate EPS procedures and training checklists for sanitation and cleaning including discharge/terminal cleaning of rooms for Veterans with infectious diseases.[50] We also reviewed the Atlanta Clinical Environment Surface Cleaning and Disinfecting Procedure guide that included steps for the cleaning and disinfection process, as well as links to CDC COVID-19 infection control guidelines.[51] We requested the EMS training program and learned that the Atlanta EMS staff use the Procedure Guide to complete cleaning; however, the EMS department does not have a separate or distinct training program for EMS employees.

We inspected the housekeeping closet and observed it to be clean and well-organized, and we observed the appropriate cleaning equipment and cleaning agents to clean the unit and to perform terminal cleaning of rooms for Veterans who are diagnosed with COVID-19.

[49] Ibid.
[50] Atlanta VA Medical Center. Environmental Management Service. Sanitation Procedure Guide 2019.
[51] Atlanta VA Medical Center. Clinical Environment Surface Cleaning and Disinfecting Procedures.

There are two EMS staff permanently assigned to 4Psych who perform general sanitation and cleaning of the unit. When a Veteran is discharged, if the two permanently assigned staff are busy with other tasks or are not on duty at the time of the discharge, any EMS staff may be assigned to terminally clean a room on 4Psych.

Knowledge about an isolation room, or a room with a COVID-19 positive Veteran, is required for EMS staff to appropriately select the chemicals used for disinfection. EMS staff and leadership interviewed appropriately described the terminal/discharge process; however, we were told that at times there is confusion and a lack of communication when identifying a room that was occupied by a Veteran who required isolation.

We were provided several variations of the terminal cleaning communication process. (1) We were told that when the EMS staff arrives on the unit to provide terminal cleaning, they must communicate with nursing staff to obtain information. (2) We were told that the nursing staff communicates with the facility bed management coordinator and that the bed management coordinator talks to EMS. (3) Finally, we were told that the charge nurse enters a request for terminal cleaning in the BMS system and process is completely automated. We learned that when staff request cleaning of the room using BMS, the requesting staff must indicate the room was used for a Veteran requiring isolation, thus providing EMS staff with information needed to select appropriate cleaning materials. We were told by EMS staff that information about isolation is not routinely included in the BMS requests for 4Psych. Our review did not find a COVID-19 infection related to this concern.

Nursing staff told us that they were not confident that rooms were appropriately terminally cleaned because they did not routinely observe the EMS staff using the optional ultraviolet light during the terminal cleaning process. We found there was a general lack of understanding that ultraviolet light was not required but was an adjunct to the 2-step terminal cleaning process. Nursing staff told us they observed EMS staff wearing PPE and using chemicals to clean rooms when Veterans are discharged.

Conclusions for Allegation 6

- We **do not substantiate** that after a Veteran who has tested positive for COVID-19 is transferred off the floor, 4Psych leadership does not require a "Terminal Cleaning" of the room – which is required following the stay of Veterans with other infectious diseases.

- Nursing staff, not leadership, is responsible for contacting EMS staff using BMS.

- Per EMS staff, rooms previously occupied by Veterans requiring isolation are not routinely identified as needing terminal cleaning in BMS requests.

- Equipment and chemical required for terminal cleaning of rooms for Veterans with infectious diseases are appropriate and available on the unit.

- The nursing staff have a lack of understanding about the requirements for use of ultraviolet light for terminal cleaning. However, EMS is responsible for this task and there is no evidence to demonstrate that EMS has a lack of understanding about the use of the ultraviolet light.

- A unit-based tiger team to address environmental issues identified during the site visit was initiated immediately following the unannounced site visit.

- Atlanta does not have a facility-wide EMS quality assurance plan.

Recommendations to Atlanta

5. Assess the BMS process for requesting terminal cleaning to ensure that nursing staff appropriately identify rooms occupied by Veterans requiring isolation. Provide training for nursing and EMS staff if required.

6. The newly established tiger team will create and implement a process to ensure that work orders for environmental issues are appropriately entered, that concerns are followed to resolution, and that environmental issues are routinely monitored.

7. Review the current training program for EMS staff to ensure that consistent cleaning and disinfection processes are utilized in accordance with facility and CDC guidelines. Develop additional training as needed to meet facility and CDC disinfection requirements.

8. Consult VHA EPS and HEFP to assist with development of an EMS focused quality assurance program.

Allegation 7

Unit surfaces that are repeatedly touched by staff and residents are not routinely or properly cleaned as required by the VA Memo.

Findings

We reviewed the Environmental Management Service Daily Logs for the past calendar year and found that the 4Psych unit was routinely cleaned. We observed EMS staff working and cleaning surfaces in the Group Rooms and cleaning handrails in the hallway. EMS staff were observed using appropriate cleaning solutions and processes. Nursing staff confirmed that the high touch surfaces on the unit are cleaned daily by EMS as required. We observed the unit and did not find surface soil or dirt on high touch areas of the unit such as handrails, doorknobs, nor did we observe soil on surfaces in the Group Room tabletop or chairs.

During the tour of the unit, we had concerns about the keyboards and phones in the nurse's station and surfaces in the medication and treatment rooms that could potentially be considered high touch areas for staff. We observed cleaning wipes on the

nurse's station desk and in the medication rooms; however, there was a general attitude among non-EMS staff that demonstrated a reluctance to participate in maintaining the cleanliness of the unit. We also observed the staff break room with non-EMS employees utilizing the area and found the table and countertop areas near the sink soiled with food and drink stains.

Atlanta SOP, Cleaning Non-Clinical Areas by Non-EMS Personnel, establishes procedures for staff cleaning of non-patient care areas such as offices and break rooms.[52] The SOP states that it must be followed by employees who require cleaning of their personal spaces or when EMS staff is not available. The SOP describes appropriate products and processes for general cleaning and disinfection. We were told by the Infection Control Program manager and the Interim Nurse Manager that 4Psych staff have been advised to wipe down surface areas and clean their work area to protect themselves and others from the spread of pathogens. We found evidence that on June 7, 2022, Infection Prevention and Control provided training for 4Psych staff on cleaning and disinfection.

We were informed that each morning there is a facility-wide "Safe Day" phone call that includes Engineering, EMS, Infection Control Services and facility leadership. Concerns on specific units, such as cleanliness, can be discussed during the call. We learned that there have been no concerns about cleanliness of the 4Psych unit voiced on the "Safe Day" call.

Conclusions for Allegation 7

- We **do not substantiate** that unit surfaces that are repeatedly touched by staff and residents are not routinely or properly cleaned as required by the VA Memo.
- EMS staff appropriately clean high touch surfaces daily as required.
- Although non-EMS staff on the unit have been educated on the importance of cleaning, there is a reluctance by non-EMS staff to participate in maintaining the unit.

Recommendations to Atlanta

9. Re-educate non-EMS staff on the importance of cleaning high touch surfaces in nursing areas such as the nurse's station and medication room and non-clinical areas such as the staff break room.
10. Establish a method to encourage and monitor the cleaning of unit surfaces by non-EMS staff. Consider employee engagement strategies to foster a culture of cooperation and collaboration in maintaining a clean and healthy unit environment.

[52] Atlanta VA Medical Center Standard Operating Procedure. *Cleaning of Non-Clinical Areas by Non-EMS Personnel.* March 14, 2022.

Allegation 8

There is dirt and grime on the floor and windows, mold and mildew in the patient shower, and insects are regularly found on the floors and walls of the unit. (This allegation was voiced by both Whistleblowers).

Findings

4Psych is a 40-bed inpatient unit consisting of two main hallways (an East and a West side) with a group room for patient use on each side, two nursing stations, two medication rooms, and two consult rooms used for one-to-one psychiatric care and counseling. There are 25 patient rooms, each with a bathroom including a toilet, sink and shower.

During the unannounced site visit, we were able to inspect 18 of the 25 (or 72%) inpatient rooms. Some rooms were occupied by Veterans, and we were unable to enter the room. We received permission from three Veterans to inspect their room while it was occupied.

We also inspected the nursing stations, both medication rooms, both consult rooms and both group rooms. We correspondingly checked the staff break room, the provider and physician assistant offices and workspace, the nourishment room used to store and prepare Veteran snacks, the supply room, the dirty utility room and the housekeeping room.

We observed the showers in the 18 patient rooms we were able to enter and found no evidence of mold or mildew in the shower or on the shower curtains as alleged.

We found the unit to be clean without the alleged dirt and grime on floors. Although we observed what appeared to be stains on the floor behind the head of some of the beds and behind some of the nightstands in patient rooms, when we touched the floor in these areas, we did not find any dirt, dust or grime. We determined that the stained appearance of the floor was due to an excess of floor wax from a prior application. We also carefully observed the windowsills, handrails and other surfaces such as tables and chairs in the group rooms and did not find any unclean surfaces.

We observed windows in the patient rooms we were able to enter. All windows were appropriately covered with Plexiglass that was sealed to the window frame to prevent opening of the window. The Plexiglass is an appropriate safety measure; however, it does create a space between the Plexiglass and the exterior window. We observed that in most rooms, including patient rooms and the group spaces, there were dead insects between the exterior windows and the Plexiglass. Although the dead insects are unsightly, this is not an unusual or unsanitary finding; there is no health hazard related to dead insects outside of the Plexiglass. We learned during our exit interview with the Director that a routine cleaning of the windows was planned for September-October of 2022. The cleaning of the windows requires removal and replacement of the safety Plexiglass and requires careful coordination with the staff on the mental health unit.

Atlanta has an active pest management program. We reviewed the Atlanta IPM Plan that requires the facility to routinely conduct pest inspections and maintain IPM Service Reports when treatment is required. As required in the Atlanta IPM Plan, when a staff member in any area observes pests, this is reported to the Pest Management Official and recorded in a Pest Management Sighting Log.[53] We reviewed the Pest Management Sighting Logs and service reports from 2020, 2021 and 2022 and found that when pests are identified, they are appropriately treated. We reviewed a Pest Management Service Report dated July 7, 2022, in response to a staff sighting of roaches in the drain of the shower in a patient room. We learned from EMS staff that insects may crawl into dry drains or drains that are not frequently used and this requires treatment by pest management. We reviewed the treatment log and found that pest management appropriately treated the drain, and the issue was resolved. During the site visit there were no live insects observed on the unit.

Conclusions for Allegation 8

- We **do not substantiate** that there is dirt and grime on the floor and windows, mold and mildew in the patient shower, and insects are regularly found on the floors and walls of the unit.

- Although there are dead insects between the safety Plexiglass and the exterior windows of the unit which are unsightly, the Plexiglass is an appropriate safety measure. Atlanta has a plan for cleaning of the windows including removal and replacement of the safety Plexiglass, a process that will include removal of the dead insects.

Recommendation to Atlanta

11. Ensure the window cleaning and Plexiglass replacement are completed as planned.

Water Temperature Allegation

Background

VHA Directive 1061, Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems, mandates that measures to prevent scald injuries from hot water be implemented in all VA medical facilities.[54] Per the directive, each VA medical facility must have a schedule for routine monitoring of facility water systems and methods to prevent scald injury. Water temperature that is discharged from outlets, such as sinks and showers, must be 110 °F or below.[55]

[53] Atlanta VA Medical Center. Integrated Pest Management Plan 2016.
[54] VHA Directive 1061 Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems. February 16, 2021.
[55] Ibid.

Allegation 9

Most sinks and showers in Veterans' rooms do not have hot water or are not functioning at all.

Findings

We entered and inspected the sinks and showers in 18 of the 25 (or 72%) patient rooms on the unit that we were able to access. All sinks are motion activated; for safety purposes there are no hot or cold faucets or water spigots. We turned on the sink in each room and found that all sinks had running water. When we used our hands to turn on the auto sensor in each of the patient rooms, the water felt cool. There is no method to turn on hot water only for activities such as hand washing. We learned that for each sink to have water that feels consistently warm at 110 °F when auto-activated, each sink requires a mixing value to be individually adjusted based on the distance of each sink from the water source. This was described by the Chief of Engineering as a balance to adjust the source water temperature and the mixing valve temperature at each sink for each patient room. We were told that because mixing valves are not present in patient sinks on the unit the water feels cool at an average temperature of 110 °F (close to body temperature) in each room.

We turned on the shower in the 18 rooms we entered. We observed that each shower is controlled with a mechanical mixing valve that is turned to control the water temperature; for safety purposes there is no method to turn on hot water only. All showers felt cool to our hands when we turned them on. We kept each shower running for 1 minute. After 1 minute, four of the showers felt warm, but none felt hot after running water. We talked to the three Veterans who were in their room during the inspection. All three Veterans told us that they were able to take a shower in appropriately warm water, but they needed to keep the water running for "a while" or up to about "10 minutes" to get the water to a comfortable temperature. No Veteran told us they were required to take a cold shower.

We reviewed all work orders for sink and shower issues on 4Psych from March 2, 2020, through the date of the site visit and found that all work orders were complete. We were informed that at one time there were several sinks that required battery replacement for the auto sensors that turn on the water. This work is complete.

We learned that the temperature of the showers on 4Psych have been a concern since the winter months of fiscal year (FY) 2022. The facility is undergoing renovations on the third floor and there are unheated vacant spaces directly underneath the 4Psych unit where the water pipes run. The renovations area being unheated leads to a cooling of the hot water pipes affecting the temperature of the water and the length of time it takes for the water to warm for patient showers. Engineering leadership told us that additional insulation was installed in the walls and floor of the third-floor construction area to help moderate the temperature of the water pipes on 4Psych.

In accordance with the requirements of VHA Directive 1061, prior to the OMI site visit, during routine maintenance, engineering staff tested the temperature of water in patient showers on the unit and found the average shower temperature to be 105 °F within 4 minutes. The lowest shower temperature found was 100 °F, the highest temperature was 110 °F. The temperature variance in the shower was determined to be caused by the distance of the shower from the water heater. The hot water temperature high limit is in accordance with VHA Directive 1061 that states the water temperature that is discharged from outlets, such as sinks and showers, must be 110 °F or below. [56]

Conclusions for Allegation 9

- We **do not substantiate** the allegation that most sinks and showers in patient's rooms do not have hot water or are not functioning at all. We found that all patient rooms have functioning sinks and showers. However, there is a delay in the time it takes for hot water in the patient sinks and showers to reach a temperature that is comfortable for patient use.

- Atlanta is compliant with VHA Directive 1061, with the highest water temperature in the shower found during testing to be 110 °F.

- The distance between the hot water source and absence of mixing valves at the patient sinks causes the hot water to feel cool when exiting the spout.

Recommendations to Atlanta

12. Continue routine monitoring of water temperature of patient showers and explore remediation options to provide up to the maximum warm water temperature of 110 °F in each patient shower on 4Psych.

13. Consider remediation options for patient sinks to provide warm water at the spout for hand washing.

Nursing Practice Allegations

Background

VHA Handbook 1160.06, Inpatient Mental Health Services, dated September 16, 2013, describes the requirements for the provision of inpatient mental health care within the Department of Veterans Affairs.[57] VHA Handbook 1160.06 requires timely access to inpatient mental health care in a safe, therapeutic, and healing environment with adequate staffing. The directive also requires inpatient units to be "staffed at a level that ensures that all patients are safe in the environment of care and to facilitate staff observation of those patients needing monitoring due to agitation, aggression, or behavioral concerns. One-on-one (1:1) care may be necessary for patients during such

[56] VHA Directive 1061 Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems. February 16, 2021.
[57] VHA Handbook 1160.06. Inpatient Mental Health Services. September 16, 2013.

times (see VHA Directive 2010-034, Staffing Methodology for VHA Nursing Personnel)."[58]

VHA Directive 2010-034 has been rescinded and replaced by VHA Directive 1351, Staffing Methodology for VHA Nursing Personnel, dated December 20, 2017, to establish a standard method to determine the appropriate direct care staffing needs to provide quality patient care.[59] According to VHA Directive 1351, each VA medical facility is required to support and implement a local staffing plan and to routinely evaluate the staffing plan to ensure safe and effective quality care.[60] VHA Directive 1351 describes staff scheduling as a process of deploying available staffing resources for the patient care needs of all clinical units of a health care organization. Scheduling relies on managerial judgment to match patient needs with available resources. The result of scheduling is the actual delivered daily Nursing Hours Per Patient Day (NHPPD) (the total number of nursing hours of care available divided by the number of patients in a 24-hour period).[61] VHA Directive 1351 requires that each VA medical facility use the staffing methodology to plan nursing personnel staffing levels. The facility must establish acceptable ranges of NHPPD for each unit based on target workload hours for specific units.[62] At VA medical facilities, the nurse managers and the Nursing Officer of the Day work collaboratively to ensure that staffing levels, skill mix and assignment of nursing personnel are consistent with VHA Directive 1351 for all units and to ensure safe clinical operations. Analysis of the staffing mix and NHPPD may result in assignment of appropriate nursing personnel to other units to support patient care and to achieve safe staffing levels.

Allegation 10

Nurses and other staff have been asked by leadership to violate the 1:1 monitoring policy outlined in VHA Handbook 1160.06, Inpatient Mental Health Services, dated September 16, 2013, and are often told to watch two Veterans at a time or monitor an entire floor instead of Veterans requiring 1:1 monitoring.

Findings

In accordance with VHA Handbook 1160.06, to maintain a safe and therapeutic environment of care, some mental health inpatients on 4Psych may need special observation. Atlanta Policy 118-45, Special Observation, outlines the facility approach for special observation patients.[63] There are three types of special observation: 1) One-to-One (1:1) is the highest level of observation and requires that staff providing 1:1 observation be assigned to one patient; 2) Line of Sight (LOS) Observation requires that staff monitoring a patient have an unobstructed view; however, staff may assume responsibility for more than one patient in the same room; and 3) Close Observation

[58] Ibid.
[59] VHA Directive 1351. Staffing Methodology for VHA Nursing Personnel. December 20, 2017.
[60] Ibid.
[61] Ibid.
[62] Ibid.
[63] Atlanta VA Health Care System Policy 118-45 Special Observation, October 9, 2019.

(Close OBS) requires the patient be monitored by nursing staff every 15 minutes, and staff can assume responsibility for more than one patient.

At Atlanta, the Office of Nursing and Patient Care Services (ONPCS) Policy 08-02, Staffing Methodology for Nursing, operationalizes and implements VHA Directive 1351.[64] The facility policy requires that nursing workload and staffing mix for each unit, including analysis of required number of employees to account for leave, education and other system improvement activities, are used to determine the safe nurse staffing levels for each unit. It is common practice for staff to be rotated to other units to assist with care such as 1:1 or LOS observation if there is adequate staffing based on the management review of the staffing methodology and the NHPPD.

On the day of the unannounced site visit, we reviewed the daily assignment sheet and found that there were 21 staff scheduled for the day shift. Three staff were rotated to Medical Units to provide 1:1 or LOS patient observation. There was no indication that Mental Health staff were rotated to other units to provide direct patient care. After accounting for the rotated staff, there were 18 staff on the unit for the shift for the 18 patients on the unit.

To further evaluate the assignment of staff to perform 1:1 monitoring on other units we reviewed the health technician assignment log from January 2022 through July 2022. We found that health technicians were routinely rotated to medical and surgical units to provide coverage for observation of Veterans. There was no indication that mental health staff were expected to provide direct patient care on other units.

Whistleblower 1 provided the assignment sheets for the following days that allegedly created a violation of the 1:1 policy: July 24, 2022; July 26, 2022; July 28, 2022; July 29, 2022; and July 30, 2022. The assignment sheets documented that health technicians were rotated to other units for observation purposes. We confirmed that health technicians were assigned to monitor two patients who required LOS observation; however, this level of observation is allowed in accordance with policy.

We were informed by nursing leadership that they were not aware of any violation of the 1:1 observation policy. Leadership told us they knew of staff concerns related to staffing and as a result, the nurse manager told us she verbally reinforced for staff that health technicians can only be rotated to another unit for observation of patients if staffing is adequate on 4Psych. The nurse manager described one situation where a technician was appropriately rotated to another unit, but the health technician was concerned about the assignment. The health technician contacted the 4Psych Nurse Manager who intervened with leadership on the other unit. The assignment was appropriately adjusted to adhere to the facility observation policy, Atlanta ONPCS Policy 08-02.[65] We found no evidence to support any violation of the 1:1 monitoring policy.

[64] Atlanta VA Health Care System. ONPCS Policy 08-02 Staffing Methodology for Nursing, August 29, 2019.
[65] Ibid.

We reviewed four Joint Patient Safety Reports (JPSR) related to 4Psych staffing and found that each JPSR evaluated staffing for the time of the complaint and determined that staffing on 4Psych was appropriate and rotation of staff to other units did not cause the staffing on the unit to fall below acceptable levels.

Conclusions for Allegation 10

- We **do not substantiate** that nurses and other staff have been asked by leadership to violate the 1:1 monitoring policy outlined in VHA Directive 1160.06 and are often told to watch two Veterans at a time or monitor an entire floor instead of Veterans requiring 1:1 monitoring.
- Nursing staff are appropriately rotated to other units to provide observation of patients when the workload and staffing mix on 4Psych is adequate.
- There is no evidence that rotating staff to other units has created a danger to patient safety on 4Psych.
- Although there was one reported incident of the inappropriate assignment of 4Psych staff to observe Veterans on another unit, the situation was immediately addressed by leadership. There have been no additional reports of inappropriate assignment on another unit.

Recommendation to Atlanta

14. Provide remedial education to nursing staff on 4Psych regarding rotation to other units to promote safety of Veterans requiring higher levels of observation and the expected compliance with rotation assignments.

Allegation 11

Inpatient Mental Health Program staff are being floated to the Emergency Department (ED) to perform COVID-19 testing in violation of the VA Memo.

Findings

Atlanta follows the guidelines established by VHA Directive 1351 to analyze staffing and deploy available staffing resources for the patient care needs on all clinical units or the facility.[66] Staff may be rotated to other units to assist with care if there is adequate staffing based on the management review of the NHPPD. We were informed by nursing leadership and 4Psych staff that during the COVID-19 pandemic, RNs and LPNs were assigned to support facility clinical needs by performing COVID-19 nasal swabbing in the ED. We reviewed verification of training for RNs and LPNs and found that 4Psych nursing staff have completed training to perform BinaxNOW Rapid COVID-19 Testing, including nasal swabbing.

[66] VHA Directive 1351. Staffing Methodology for VHA Nursing Personnel. December 20, 2017.

4Psych staff refused the assignment to work in the ED for their shift. Staff told us they refused this assignment because they were concerned that they might be asked to perform other duties in addition to COVID-19 testing. However, per leadership, we heard no indications that these nurses would have been assigned any duties other than nasal swabbing for which they were trained.

Whistleblower 1 also informed us that rotation of staff to other units was problematic because it created a staffing shortage on 4Psych. To determine if assignment of 4Psych staff to the ED to assist with COVID-19 swabbing may have created a staffing shortage on the unit, we reviewed the nursing staffing levels for 4Psych during the months of the COVID-19 pandemic from October 2020 through July 2022. We found that NHPPD consistently exceeded the calculated benchmark of 11.2 NHPPD. In FY 2021, the average NHPPD was 12.2, and in FY 2022, the average NHPPD was 14.8. In addition, as previously discussed, the average daily census on the unit was below the maximum for the duration of the COVID-19 pandemic (Figure 3, page 15).

As noted above, we reviewed four JPSRs related to 4Psych staffing and found that each JPSR evaluated staffing for the time of the complaint and determined that staff on 4Psych was appropriate and rotation of staff to other units did not cause the staffing on the unit to fall below acceptable levels.

Conclusions for Allegation 11

- We **do not substantiate** that Mental Health Program staff are being floated to the ED to perform COVID-19 testing in violation of the VA Memo.
- Based on review of the NHPPD and the average daily census on the 4Psych unit, it is unlikely that rotation of staff to other units would have created a staffing shortage or an unsafe nursing staff mix on the unit.
- Although Nursing staff on 4Psych were trained to perform nasal swabbing for COVID-19 testing, they refused their assignment to assist the ED during the COVID-19 pandemic.

Recommendation to Atlanta

15. Review the circumstances of the refusal of assignment by nursing staff and take administrative action, if appropriate.

Additional Findings

We interviewed six nursing staff who work on 4Psych. All nursing staff expressed frustration with a lack of communication and consistent leadership. We learned that the Nurse Manager position has been vacant since June 2021 and the two Assistant Nurse Manager positions have been vacant since June 2020 and July 2021. A third Assistant Nurse Manager position was recently added to the organizational chart for 4Psych; this new position is also vacant. We reviewed the recruitment actions for the nursing

management positions and found that a selection for the Nurse Manager was made in March 2022, but the candidate declined the position. At the time of the site visit, we learned that a non-competitive hire was made in August 2022 and the Enter on Duty date was pending. The recruitment efforts for two of the Assistant Nurse Managers have resulted in no selections; most recently another certificate for recruitment was requested by the Chief Nurse on July 18, 2022. There have been no recruitment efforts for the third Assistant Nurse Manager position as this position is new.

During the absence of permanent nursing leadership on the unit, the position has been temporarily filled with 45-day rotations by other nurse managers including the Outpatient Clinic Nurse Manager, the Chief Nurse of Mental Health Nursing and the Nurse Manager for the Domiciliary Residential and Rehabilitation Treatment Program. Additionally, a Nurse Manager from the Augusta, Georgia VAMC was detailed to Atlanta from November 2021 through March 2022.

We were told by clinical staff that although the acting nurse managers were present on the unit some of the time, they felt the lack of permanent leadership was a source of poor morale on the unit. We reviewed the All-Employee Survey (AES) results for FY 2020 and FY 2021 and found that there is an opportunity for improvement in the areas of employee engagement, workgroup respect, workgroup civility and reduction of employee burnout. Additionally, there is a lack of staff engagement, lack of staff cooperation and a pervasive sense of hopelessness attributable to the extended vacancies in key leadership positions on 4Psych.

Additional Findings Conclusion

- The lack of permanent Nursing Leadership on 4Psych may have contributed to poor employee morale as evidenced by AES results for FY 2020 and FY 2021.

Recommendations to Atlanta

16. Actively recruit and hire nursing leadership positions for 4Psych including the Nurse Manager and three Assistant Nurse Managers.

17. Consult with an external office to conduct an assessment of the environment on 4Psych that has contributed to the poor morale and lack of cooperation among staff. Consider a consultation with the Office of the Chief Human Capital Officer and/or the National Center for Organization Development for workplace civility training to strengthen workforce engagement and employee satisfaction.

VI. Summary Statement

We developed this report in consultation with other VHA and VA offices to address OSC's concerns that employees engaged in conduct that may constitute a violation of a law, rule or regulation; engaged in gross mismanagement; or created a substantial and specific danger to public health. We reviewed the allegations and determined the merits of each, and the National Center for Ethics in Health Care has provided a health care

ethics review. We substantiated an allegation related to social distancing on the unit for hospitalized psychiatric patients and a delay in the time it takes for hot water to arrive at the patient sinks and showers due to pipe and building structural work. We found no direct concerns causing a specific danger to public health.

Attachment A

Department of Veterans Affairs

Memorandum

Date: March 16, 2020

From: Deputy Under Secretary for Health for Operations and Management (1ON)

Thru: Assistant Deputy Under Secretary for Health for Clinical Operations (10NC)

Subj: Managing Operations of Mental Health Unit While Managing COVID-19
Veterans Integrated Service Network (VISN) Directors (10N1-23)

To: VISN Mental Health Liaison (10N1-23)

1. While elective procedures and admissions in general may be curtailed at this time, admissions to inpatient mental health units and Mental Health Residential Rehabilitation Treatment Programs (MHRRTP) are often based upon emergent or urgent need to address an immediate life-threatening crisis or other situation of high risk. Similarly, it is critical to maintain continuity in opioid treatment care. Please utilize the attached guidance documents to guide local decision-making regarding admissions to and operations of inpatient mental health units and MHRRTPs.

2. Questions should be directed to [redacted] Executive Director, Office of Mental Health and Suicide Prevention at [redacted]@va.gov.

[redacted]

Attachments
Attachment A- Guidance for VA Inpatient Mental Health Programs
Attachment B- Guidance for VA Mental Health Residential Rehabilitation Treatment Programs (MHRRTP)
Attachment C- Guidance for Managing Positive Hospitalized Suicidal Patients
Attachment D- Guidance for VA Opioid Treatment Programs

Attachment A

Department of Veterans Affairs (VA)
Veterans Health Administration (VHA)
Guidance for VA Inpatient Mental Health Programs

Purpose: This document provides guidance to facilities operating Inpatient Mental Health Programs located at VA medical centers. **This guidance is intended to inform the development of local facility policy and procedures for prevention, screening and surveillance of the Coronavirus (COVID-19) on Inpatient Mental Health Programs.** Please refer to VHA COVID-19 Strategic Response Plan by VHA COVID-19 Workgroup Emergency Management Coordination Cell v1.0 released on March 3, 2020, for VHA Department-wide COVID-19 planning, including modifying responses based on the phase of the COVID-19 outbreak.

Synopsis: The priority goal in the VA response to COVID-19 is the protection of Veterans and staff. Inpatient Mental Health Programs provide an inpatient level of care to Veterans that may be at risk for COVID-19 because of their current mental and medical health conditions and for some, a recent history of homelessness. Inpatient Mental Health Programs are open to visitors from the community therefore exposure to the community is possibly recurring during their length of stay. Various strategies to mitigate exposure to and transmission of COVID-19 to Inpatient Mental Health Veterans and staff are critical.

Prevention: The best method to combat any infectious disease on an Inpatient Mental Health Program is to have preventive measures in place, prior to an outbreak, that mitigate the transmission and spread of the disease. This includes:

- Pre-screening all referrals and requiring a current temperature. If a Veteran has a positive screen, they will need triage following local established protocols.
- Re-screening all admissions once they arrive on inpatient unit.
- Re-screening all visitors before they enter the unit (even though screened at main entrance). This may change to eliminating visitors at some point.
- All patients will receive BID vital signs at a minimum with reports of all temps over 99.0 to a licensed provider and Nurse Manager
- All Veterans receive daily huddle regarding hand hygiene and reminders prior to meals.
- Instructing to ask nursing staff for hand sanitizer as desired
- Laminated hand hygiene signage placed in bathrooms and bulletin boards
- Hand sanitizer dispensers placed at door to nursing station
- All staff given individual hand sanitizers to keep on person
- All high touch areas should be cleaned at least twice per day or prior to each shift
- Stocking necessary PPE on the unit for contingency purposes
- Frequent handwashing with soap and water for minimum of 20 seconds
- Veterans are not permitted to possess or use alcohol-based hand sanitizers unless under the direct supervision of a staff member.

- Avoid shaking hands when in situations where access to soap/water or sanitizers is not available (inform people why you are not shaking hands).
- Avoid touching your face.
- Avoid public places and areas where large groups of people will congregate.
- Staff and patients will be provided a copy of the attached Poster: "Stop the Spread of Germs" new COVID-19 Poster.

Further information about everyday preventive actions:
https://www.cdc.gov/coronavirus/2019-ncov/about/prevention-treatment.html

Follow your VAMC policy regarding management of positive screens. Access copy at https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/SitePages/Home.aspx

Staffing: Staffing, procedures and delivery models should be assessed to limit the number of non-Inpatient Mental Health Program staff and contractors entering Inpatient Mental Health program space. Deliveries (e.g., pharmacy, supplies, linens) should be limited, when possible. Inpatient Mental Health Program staff should not have duties that require them to enter a COVID-19 area at the facility. Staff will not be floated between these units from other areas when possible.

Inpatient Mental Health Program Access: All Inpatient Mental Health staff and patients must follow local facility policy and procedures for accessing the Inpatient Mental Health Unit. The Inpatient Mental Health patients and staff must be trained in the locally developed Inpatient Mental Health Program procedures for the prevention, screening and surveillance of COVID 19. Access to the Inpatient Mental Health Program should be limited and able to accommodate screening of all patients, visitors, contractors and potentially staff. Appropriate signage should be in place to direct visitors to the access point. Screening criteria may change as information about COVID-19 evolves. As of the effective date, screening should include the following information:

1. Do you have any of the following?
   - Fever (100.4 °F or 38 °C)
   - New or worsening cough
   - Shortness of breath
   - Flu-like symptoms

   Yes No

2. Have you or a close contact traveled to an area with widespread or sustained community transmission of Coronavirus Disease 2019 (COVID-19) within 14 days of symptom onset?
   Yes No

3. Have you been in close contact with a person, including a health care worker, with confirmed (COVID-19)?
   Yes No

A **positive** screen is "Yes" to any part of question #1 AND "Yes" to question #2 and/or #3. Inpatient Mental Health Programs will follow protocols as indicated for providing a mask to the patient and anyone with the patient; moving the patient to the nearest room to isolate the person from the rest of the patients on the unit (as best you can) while awaiting acute care bed transfer. Once transferred to an acute care medical bed, medical team evaluates and performs necessary diagnostic testing and treats as indicated.

Veterans who are currently admitted and who leave the building for an on-station outpatient clinic appointment will be screened using the questions in #1 upon return to the unit. There is no requirement to complete questions #2 and #3. Veterans who are currently admitted and leave the unit for an off-station appointment will be screened using questions #1, #2 and #3 when they return to the unit.

Surveillance: Patients observed or reported to be ill will be required to report to Nursing and/or 24/7 staff for evaluation or referral for evaluation for possible infection. Inpatient Mental Health Programs will follow protocols as indicated for providing a mask to the patient and anyone with the patient; moving the patient to the nearest room to isolate the person from the rest of the patients on the unit; call a code "ICE" (Infection Control Emergency) on VOCERA (or other communication device); transport the patient to the Emergency Department or other medical setting as indicated. Existing protocols that rule out other viral disease (e.g., influenza) should be performed prior to any COVID-19 testing. The information collected should be entered in CPRS. Any patient that screens positive should be assessed for COVID-19 testing.

Isolation Plan: The Inpatient Mental Health Program should have a plan to isolate any patient that is suspected of having COVID-19. Inpatient Mental Health Programs do not have negative airflow rooms and should identify an area, such as a vacant room or office, on the unit that can be used to confine patients, away from the other patients, until transported to the Emergency Department or other medical setting as indicated for further evaluation or consultation with Infection Control for further guidance. Facilities with multiple suspected or confirmed cases should have plans to isolate patients to one pod or floor in the Inpatient Mental Health Program or at another location at the medical center if space does not allow to isolate in the Inpatient Mental Health Program. Patients currently being treated in the Inpatient Mental Health Program will not be relocated to other locations in the facility unless medically indicated.

Visitors: The goal is to approve access to individuals with no fever and no symptoms. Visitor access will be greatly limited to include limited visiting hours. All visitors will be screened for COVID-19 as described above. Visitors who screen positive, will not be granted access to the Inpatient Mental Health Program. Visitors without symptoms will be permitted to enter the Inpatient Mental Health Program as dictated by the current policy. Visitors with additional questions about their symptoms should be referred to their medical professional and follow established facility guidelines.

Social Distancing: Inpatient Mental Health Programs should initiate procedures to limit social activities that bring together groups of patients. Group size should be limited to five patients, if possible. Since Veterans eat in a designated dining area, Veterans should be reminded to practice infection prevention methods that include frequent handwashing with soap and water for 20 seconds minimum, avoid touching face, avoid close contact (within 6 feet) of anyone who is sick; not going to the dining hall or other public places if sick.

Restrictions: Veterans who have a fever, cough, shortness of breath or flu-like symptoms must be restricted to the Inpatient Mental Health Program or other designated unit at the medical center during this period for closer monitoring by staff thus minimizing interactions with other patients and staff. Veterans must be limited to their rooms and tray service provided. If necessary, a patient may be moved to a single room or a double room without a roommate, if there are no contraindications. Monitoring will consist of Veterans being screened at least twice per 24-hour period for fever and symptoms. The restriction period will last for a total of 14 days including the time already spent in the hospital for Veterans admitted from a ward at the facility.

Attachment B

Department of Veterans Affairs (VA)
Veterans Health Administration (VHA)
Guidance for VA Mental Health Residential Rehabilitation Treatment Programs (MHRRTP)

Effective Date:

Purpose: This document provides guidance to facilities operating Mental Health Residential Rehabilitation Treatment Programs (MHRRTP) located on medical center grounds and in the community. **This guidance is intended to inform the development of local facility policy and procedures for prevention, screening and surveillance of the Coronavirus (COVID-19) on MHRRTP units.** Please refer to VHA COVID-19 Strategic Response Plan by VHA COVID-19 Workgroup Emergency Management Coordination Cell v1.0 released on March 3, 2020, for VHA Department-wide COVID-19 planning, including modifying responses based on the phase of the COVID-19 outbreak.

Synopsis: The priority goal in the VA response to COVID-19 is the protection of Veterans and staff. Mental Health Residential Rehabilitation Treatment Programs (MHRRTPs) otherwise known as Domiciliary Care Programs include facilities that may be located on VA grounds in the main medical center building, in a separate building on the medical center campus or in a separate community-based location.

MHRRTPs provide a residential level of care to Veterans who may be at risk for COVID-19 because of their current medical and mental health conditions and for many, a recent history of homelessness. MHRRTPs are open residential units and Veterans may leave the facility for work, appointments or on pass; therefore, exposure to the community is possibly recurring during their length of stay. Various strategies to mitigate exposure to and transmission of COVID-19 to MHRRTP residents and staff are critical. MHRRTP program and nurse managers should be part of local VAMC COVID19 Response teams to make local VAMC leaders aware of their particular care delivery process.

Prevention: The best method to combat any infectious disease on a MHRRTP unit is to have preventive measures in place, prior to an outbreak, that mitigate the transmission and spread of the disease. This includes:

- Frequent handwashing with soap and water for minimum of 20 seconds.
- Frequent use of 60% or greater alcohol-based sanitizers (individualized care for Veterans with an Alcohol Use Disorder must be considered to minimize the risk of abuse of alcohol-based sanitizers).
- Avoid shaking hands when in situations where access to soap/water or sanitizers is not available (inform people why you are not shaking hands).
- Avoid touching your face.
- Increase cleaning of unit surfaces that are repeatedly touched by staff and residents.
- Avoid public places and areas where large groups of people will congregate including facility specific plans for social distancing in dining halls, group rooms, lounges, etc.
- Facilities should provide staff and residents a copy of the attached Poster: "Stop the Spread of Germs" new COVID-19 Poster.

Further information about everyday preventive actions:
https://www.cdc.gov/coronavirus/2019-ncov/about/prevention-treatment.html

Follow your VAMC policy regarding management of positive screens. Access copy at https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/SitePages/Home.aspx

Admissions: Curtailing admissions to MHRRTPs is not currently recommended, however, since this is an evolving situation, this may change. Curtailing MHRRTP admissions will be based on the local facility evaluation of risk to staff and Veterans. Facilities must submit an Issue Brief if admission to the MHRRTP is curtailed and provide alternative services to all Veteran whose admission is delayed or cancelled. Veterans, who are screened and accepted for admission and are placed on the wait list, will be followed in accordance with current MHRRTP policy for waiting Veterans. When a Veteran presents for admission, the Veteran will follow the local facility policy and procedures for accessing the campus and for screening using the Call Center/Clinical Contact Center (CCC) Coronavirus Disease 2019 (COVID-19) Screen.

Staffing: Staffing, procedures and delivery models should be assessed to limit the number of non-MHRRTP staff and contractors entering MHRRTP space. Deliveries (e.g., pharmacy, supplies, linens) should be limited, when possible. MHRRTP staff should not have duties that require them to enter a COVID-19 area at the facility. MHRRTP staff must be provided the appropriate personal protective equipment for responding to a positive screen for COVID-19.

MHRRTP Unit Access: All MHRRTP staff and residents must follow local facility policy and procedures for accessing the campus. The MHRRTP residents and staff must be trained in the locally developed MHRRTP unit procedures for the prevention, screening

and surveillance of COVID 19. Access to the MHRRTP unit should be limited to one entrance and able to accommodate screening of all residents, visitors and potentially staff. Screening criteria may change as information about COVID-19 evolves. As of the effective date, screening should include the following information:

1. Do you have any of the following?
   - Fever (100.4 °F or 38 °C)
   - New or worsening cough
   - Shortness of breath
   - Flu-like symptoms

   Yes No

2. Have you or a close contact traveled to an area with widespread or sustained community transmission of Coronavirus Disease 2019 (COVID-19) within 14 days of symptom on-set?
   Yes No

3. Have you been in close contact with a person, including a health care worker, with confirmed (COVID-19)?
   Yes No

A **positive** screen is "Yes" to any part of question #1 AND "Yes" to question #2 and/or #3. MHRRTPs will follow protocols as indicated for providing a mask to the resident and anyone with the resident; moving the resident to the nearest designated room to isolate the person from the rest of the residential community; call a code "ICE" (Infection Control Emergency) on VOCERA (or other communication device); and communicate and coordinate transport of the resident to the Emergency Department per local facility procedures. If the resident, staff member or visitor has screened positive for COVID-19, the MHRRTP program will follow local facility policy and procedures to determine if further testing of staff and residents is necessary or if isolation is required. Veterans who screen positive and refuse to follow local facility infection control policy may be discharged from the MHRRTP after appropriate discharge planning and with appropriate and authorized communication with state and local health officials.

Veterans who are currently admitted and who leave the building for an on-station outpatient clinic appointment will be screened using the questions in #1 upon return to the building. There is no requirement to complete questions #2 and #3. Veterans who are currently admitted and leave the unit for an off-station appointment, work or go on pass will be screened using questions #1, #2 and #3 when they return to the unit. All off-station passes, and recreational activities not deemed critical to the Veterans treatment may be cancelled on a weekly basis based on a local evaluation of risk.

Surveillance: Residents observed or reported to be ill with symptoms suggestive of COVID-19 as per COVID-19 screener will be required to report to Nursing and/or 24/7 staff for evaluation or referral for evaluation for possible infection. MHRRTPs will follow protocols as indicated for providing a surgical mask to the resident and anyone with the

resident; moving the resident to the nearest room to isolate the person from the rest of the residential community; call a code "ICE" (Infection Control Emergency) on VOCERA (or other communication device) communicate and coordinate transport of the resident to the Emergency Department (ED). Existing protocols that rule out other viral disease (e.g., influenza) should be performed prior to any COVID-19 testing when COVID-19 testing is available. The information collected should be entered in CPRS. Any resident that screens positive for COVID-19 should be assessed for COVID-19 testing.

Isolation Plan: The MHRRTP should have a plan to isolate any resident that is suspected of having COVID-19. MHRRTPs do not have negative airflow rooms and should identify an area, such as a designated vacant room or office, on the unit that can be used to confine residents, away from the general public, until transported to the Emergency Department for further evaluation or consultation with Infection Control for further guidance. Proactive planning should include scenarios for when multiple suspected or confirmed cases exits, such as isolating residents to one pod or floor in the MHRRTP or at another location at the medical center if space does not allow to isolate in the MHRRTP. Residents currently residing in the MHRRTP will not be relocated to other locations in the facility unless medically indicated.
Visitors: During the heightened risk for COVID-19, facilities may institute a ban on all visitors to the MHRRTP unit and to residents both on and off the unit.

Social Distancing: MHRRTPs should initiate procedures to limit social activities that bring together groups of residents. Examples include activities and games, field trips and other activities that take residents outside the MHRRTP may be paused until further notice. Since Veterans eat in a designated dining area, Veterans should be reminded to practice infection prevention methods that include frequent handwashing with soap and water for 20 seconds minimum, avoid touching face, avoid close contact (within 6 feet) of anyone who is sick; not going to the dining hall or other public places if sick.

Restrictions: Veterans who have a fever, cough, shortness of breath or flu-like symptoms must be restricted to the MHRRTP or other designated unit at the medical center during this period for closer monitoring by staff minimizing interactions with other residents and staff. Veterans must be limited to their rooms and tray service provided. If necessary, a resident may be moved to a single room or a double room without a roommate, if there are no contraindications. No day or overnight passes with be authorized during this time for identified residents. Monitoring will consist of Veterans being screened at least twice per 24-hour period for fever and symptoms. The restriction period will last for a total of 14 days including the time already spent in the hospital for Veterans admitted from a ward at the facility. Veterans who screen positive and refuse to follow local facility infection control policy may be discharged from the MHRRTP after appropriate discharge planning and with appropriate and authorized communication with state and local health officials.

Mental Health Residential Rehabilitation Treatment Programs (MHRRTPs) Located Off-Station

MHRRTPs that are located off-station will follow the same procedures above. MHRRTPs will follow protocols as indicated for a positive screen and provide a mask to the resident and anyone with the resident; moving the resident to the designated room to isolate the person from the rest of the residential community. The MHRRTP residents and staff must be trained in the locally developed unit procedures for the prevention, screening and surveillance of COVID-19.

Local procedures will be developed to call a code "ICE" (Infection Control Emergency) and for communicating and coordinating the transport of the Veteran to the VA medical center's emergency department or a community emergency department. If the resident, staff member or visitor has tested positive for COVID-19, the MHRRTP program will follow local facility policy and procedure to determine if further testing of staff and residents is necessary or if isolation is required.

Compensated Work Therapy- Transitional Residences

Local facility policy and procedures for the screening and surveillance of COVID-19 must include procedures for Veterans in the Compensated Work Therapy/Transitional Resident (CWT/TR) programs. The Compensated Work Therapy-Transitional Residence (CWT-TR) programs are group homes designed for Veterans whose rehabilitative focus is based on employment and continuing outpatient care. CWT/TR beds are official VA operating beds and are listed on the local facilities Gains and Losses Sheet as a facility ward or unit. Most of the CWT/TR programs are VA-owned houses in the community and do not have 24/7 paid VA staff on site. A live-in House Manager generally provides this on-site supervision. House Managers may be a senior resident or patient, a graduate of the CWT-TR, or a volunteer. The House Manager and residents must be trained in the specific CWT/TR procedures for the prevention, screening and surveillance of COVID-19.

If the House Manager or residents observes or if a resident reports an illness that includes a fever, coughing or shortness of breath, the House Manager must immediately report the illness to the designated CWT/TR staff or other designated VA medical facility personnel. The resident should be given a mask and confined to the Veteran's bedroom. Local procedures will be developed to call a code "ICE" (Infection Control Emergency) and for communication and coordinating the transport of the Veteran to the VA medical center's emergency department or a community emergency department. If the resident, staff member or visitor has tested positive for COVID-19, the CWT/TR program will follow local facility policy and procedure to determine if further testing of staff and residents is necessary or if isolation is required.

For further questions about the MHRRTP guidance, contact [redacted] National MH Director, MHRRTPs at [redacted]@va.gov.

Attachment C

Guidance for Managing Hospitalized COVID-19 Positive Patients Who Are Suicidal

In the event that a Veteran test positive for COVID-19 and requires hospitalization for a medical condition or for a psychiatric condition, they should be moved to the facility's COVID-19 Zone, as described in the Veteran Health Administration COVID-19 Strategic Response Plan (3/3/20). If the Veteran voices suicidal ideation or intent, it is recommended that the following procedure be followed:

1) Veteran should be placed on 1:1 observation, as described in VHA Directive 1167. The Directive defines 1:1 observation as the following:

   One-to-one observation is defined as the constant observation of one patient by one staff. Staff providing one-to-one observation should only be observing one patient at a time and have no other responsibilities during the assignment to one-to-one observation. While under one-to-one observation, any restroom visit requires an escort who can visually monitor the patient for suicidal behavior. Such restrictions on the Veteran's freedom must be consistent with statutory and regulatory authority and be sensitive to privacy and dignity. Observation by cameras cannot substitute for one-to-one observation. (See table on the following pages for additional information)

2) The room where the Veteran is placed should have all non-essential equipment removed. All equipment that is only used temporarily should be removed when not in use.
3) Consult should be placed to the Mental Health Consultation- Liaison team to assess the Veteran's mental health condition, determine level of suicidality, and to suggest treatment/management options.
4) Traffic in and out of the Veterans room should be kept at a minimum, with only those with a need to enter be allowed to do so.
5) No outside visitation will be allowed.

All individuals entering the Veteran's room should be clad in appropriate Personal Protective Equipment. For all routine patient care, staff should wear a surgical mask as N95 masks or PAPRs are reserved ONLY for procedures at high risk of generating aerosols (intubation, CPR, nasopharyngeal/oropharyngeal swabbing, bronchoscopy, non-invasive ventilation like Bipap or nebulizer treatments).

Guide to Various Safety Observation Levels

Safety Observation Status	Description of Observation	Documentation Frequency
Routine admission (15) or Intermittent (30) Patient Observations	Proximity: Direct visual face-to-face interaction/observation at specific intervals or designated frequency defined by policy. Typically, all newly admitted patients are initially placed on this level of observation unless care needs require a higher level of observation. This observation level entails staff are monitoring the patient's behavior, welfare, safety, location and immediate environment at Q 15 minutes or Q 30 minutes	Routine observation is documented on each patient for that unit (area of care) for the ordered time intervals of observation (Q 15 minutes/Q 30 minutes). Documentation in the medical record includes: The rationale for the observation; patient's behavior; activity; safety; unit location; at Q 15 minutes or Q 30 minutes and is also included in the treatment plan.
Direct Line of Sight Observation.	Direct line-of-sight observation is defined as continuous observation by staff. Staff can observe multiple patients but must remain safely in the area with patients such that, if a patient needs immediate intervention, the staff member can safely intervene and call other staff to help as needed. Observation by cameras cannot substitute for direct line-of-sight observation.	Direct line of sight observation of the patient is continuously maintained and documented in the medical record as 'maintained' for each shift or time required along with the rationale for the observation. The treatment plan is updated to reflect the observation.

Line of Sight: Medical equipment only	One staff member observes two or more (depending on the space configuration and the sight lines) patients (who are assessed as non-suicidal) with medical equipment at a time. (Continuous Positive Airway Pressure machines, oxygen tubing, power cords, etc.).	Direct line of sight observation of the medical equipment is continuously maintained and documented in the medical record as 'maintained' for each shift or time required along with the rationale for the observation. The treatment plan is updated to reflect the observation. Line of sight for medical equipment-is to be facilitated face-to-face in person and not via camera monitoring.
One-to-One Observation. (To be utilized for high-risk suicidal patients in all settings)	This is an 'Arm's length' away constant observation which requires constant visualization of the patient. The staff member is always within an arm's length from the patient including when using the bathroom, shower, etc.	Constant observation is documented as 'maintained' on each patient for that unit (area of care) for each shift or time required and is documented in the medical record. Documentation includes the rationale for the observation; patient's behavior; activity; safety; and unit location. The treatment plan is updated to reflect the observation.

	One-to-one observation is defined as the constant observation of one patient by one staff. Staff providing one-to-one observation should only be observing one patient at a time and have no other responsibilities during that time. While under one-to-one observation, any restroom visit requires the staff member to escort and visually monitor the patient for safety and suicidal behavior. Such restrictions on the Veteran's freedom must be consistent with statutory	
	and regulatory authority and be sensitive to privacy and dignity. **Note:** Observation by cameras cannot substitute for one-to-one observation. If the patient is agitated or has a potential for violence, the staff member should consider observation at 2-3 arm's length away and patient behaviors should be discussed with the treatment team.	

Attachment D

Department of Veterans Affairs (VA)
Veterans Health Administration (VHA)
Guidance for VA Opioid Treatment Programs (OTP)

Effective Date:

Purpose: This document provides guidance to facilities operating Opioid Treatment Programs (OTP) located on medical center grounds and in the community. This guidance is intended to inform the development of local facility policy and procedures for prevention, screening and surveillance of the Coronavirus (COVID-19) and continuity of operations. Please refer to VHA COVID-19 Strategic Response Plan by VHA COVID- 19 Workgroup Emergency Management Coordination Cell v1.0 released on March 3, 2020, for VHA Department-wide COVID-19 planning, including modifying responses based on the phase of the COVID-19 outbreak.

Synopsis: The priority goal in the VA response to COVID-19 is the health and safety of Veterans and staff. Ensuring the health and safety of Veterans diagnosed with opioid use disorder (OUD) includes ensuring uninterrupted access to medication for the treatment of OUD (M-OUD) provided in outpatient treatment settings and by the accredited Opioid Treatment Programs (OTP) in VA. OTPs may be located on VA grounds in the main medical center building, in a separate building on the medical center campus or in a separate community-based location. OTP operations are regulated by the Substance Abuse and Mental Health Services Administration (SAMHSA). As such, OTPs are encouraged to review any guidance provided directly by SAMHSA. While VA OTPs are not licensed by the State and generally do not follow State specific regulations, OTP Medical Directors are encouraged to monitor guidance from their State Opioid Treatment Authority to ensure awareness of recommendations that account for local variance in prevalence of the COVID-19.

https://www.samhsa.gov/medication-assisted-treatment/statutes-regulations-guidelines/covid-19-guidance-otp

State Opioid Treatment Authorities: https://dpt2.samhsa.gov/regulations/smalist.aspx

OTP Emergency Response Plan: Each Opioid Treatment Program is required to have an emergency response plan to ensure continuity of services in the event of an emergency or natural disaster. Programs are encouraged to review their emergency response plan at this time. The emergency response plan is required to include:

- Identification of an alternate accredited OTP for dosing or an alternate dosing location for use by the VA OTP. If the new dosing location is not within the same building as the current OTP, please see https://www.deadiversion.usdoj.gov/disaster_relief.htm to request DEA assistance in relocating your OTP DEA registered address to a new location.

- Maintenance of a 24-hour telephone answering capacity to respond to facility emergencies with contingencies plans if phone service is disrupted;
- An active roster of patients and log of medication dosages that are easily accessible (programs must ensure that if not integrated directly into the VA Electronic Health Record, medications are manually entered into the VA Computerized Patient Record System (CPRS) as non-VA medications); and
- A specific plan for how information will be communicated to Veterans in advance of and following any disruption in program operations.

Prevention: The best method to combat any infectious disease is to have preventive measures in place, prior to an outbreak, that mitigate the transmission and spread of the disease. This includes:

- Frequent handwashing with soap and water for minimum of 20 seconds using a paper towel to turn off faucet to prevent recontamination.
- Frequent use of 60% or greater alcohol-based sanitizers with placement at each dosing window (individualized care for Veterans with an Alcohol Use Disorder must be considered to minimize the risk of abuse of alcohol-based sanitizers).
- Avoid shaking hands when in situations where access to soap/water or sanitizers is not available (inform people why you are not shaking hands).
- Avoid touching your face.
- Increase cleaning of unit surfaces that are repeatedly touched by staff and residents to include areas around the dosing window.
- Avoid public places and areas where large groups of people will congregate including facility specific plans for social distancing in group rooms, lounges, etc.
- Facilities should provide staff and residents a copy of the attached Poster: "Stop the Spread of Germs" New COVID-19 Poster.

OTPs, in collaboration with infection control subject matter experts at the facility, are encouraged to evaluate standard operating procedures for completion of breathalyzers. This critical function must be continued, but collection procedures may need to be modified to minimize the risk for spread of the disease. In addition, programs are encouraged to review dosing procedures to determine whether other mitigation strategies may be warranted (i.e., use of disposable covers, providing pre-filled cups of water).

Further information about everyday preventive actions:
https://www.cdc.gov/coronavirus/2019-ncov/about/prevention-treatment.html

Follow your VAMC policy regarding management of positive screens. Access copy at
https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/SitePages/Home.aspx

Admissions: Curtailing admissions to the OTP is not recommended. However, facilities are encouraged to consider alternate treatment modalities for newly identified Veterans requiring treatment for OUD. This should include consideration for prescribing of buprenorphine/naloxone in an office-based outpatient setting with appropriate

psychosocial support that can be provided via VA Video Connect (VVC). Facilities must submit an Issue Brief if OTP operations are curtailed and must activate emergency response procedures to ensure continued access to M-OUD through an alternate OTP for dosing or an alternate location for use by the VA OTP (see earlier guidance).

Staffing: OTP staff must be provided the appropriate personal protective equipment to respond to a positive screen for COVID-19. Programs are encouraged to identify additional staff with designated credentials to ensure continuity of operations (i.e., dispensing of methadone, patient orders) in the event that OTP staff are not available to provide direct patient care.

Surveillance: All OTP staff and patients must follow local facility policy and procedures for accessing the campus. OTP staff must be trained in locally developed procedures for prevention, screening, and surveillance of COVID-19. NOTE: Current VA guidance on prevention, screening, and surveillance can be found here: https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/SitePages/Home.aspx.

Patients observed or reported to be ill with symptoms suggestive of COVID-19, influenza like illness (ILI), as per the COVID-19 screen should be provided a mask, assessed for self-harm or suicide and then safely moved to a room with a closed door. Appropriate PPE should be provided to staff prior to determining the next steps for provision of clinical care. The Veteran should be provided with their medication dose from staff with appropriate PPE while awaiting determination of the next steps for provision of clinical care.

Social Distancing: OTPs should initiate procedures to limit the number of Veterans congregating in the clinic. Procedures may include:

- Increasing times available for dispensing to avoid crowding;
- Reviewing current schedules for receipt of take-home medications to distribute assigned dispensing times across the week;
- Implementing procedures to provide space between patients presenting for receipt of their medication (i.e., marking spaces in line, requesting patients remain seated until called);
- Providing psychosocial services, to include groups, via VVC.

Dosing Considerations: Programs are encouraged to proactively review all patients admitted to the program to determine whether take-home medication can be implemented and/or increased consistent with current regulations. A determination to deviate from current federal regulations for take-home medication must be made at the level of the individual Veteran based on assessed patient risk. If indicated, programs should submit a request for an exception through the SAMHSA OTP Extranet website. Programs are encouraged to communicate to patients the need to contact the clinic in advance if they become sick, so that approval for take-home medications can be obtained and to discuss how the patient will receive the medication, possibly through the designation of another trusted individual to pick up the medication.

The need to submit a request for an exception or receive formal approval through the SAMHSA OTP Extranet should not be a barrier to providing take-home medications when determined to be medically appropriate. SAMHSA has issued guidance providing for a 48-hour window for completion of the exception request.

Programs with active community spread of COVID-19 may elect to submit a request for a blanket exception for all patients who have tested positive for COVID-19 or who are asked to quarantine allowing for take home medications. In all cases, there should be a clinical review to determine the most appropriate course of action for the Veteran. Additional dosing considerations for Veterans known to be positive for COVID-19, experiencing ILI or who are asked to quarantine are provided below.
Federal regulations for take-home medications can be found at:
https://www.samhsa.gov/medication-assisted-treatment/opioid-treatment-programs/submit-exception-request.

Programs are encouraged to consider what procedures will be implemented to allow Veterans to retain access to medications in the event they are asked to self-quarantine, report a positive test for COVID-19, or report ILI. OTPs can dose patients who present to the OTP with ILI in a separate room or unit if take home doses of methadone are not clinically appropriate. When providing services to a Veteran potentially or known to be positive for COVID-19 appropriate precautions must be taken to ensure the safety of the Veteran, other Veterans receiving care at the medical center, and OTP staff.

Access to M-OUD must be sustained for any patient assessed as unsafe to manage take-home medications or only able to manage a limited supply of take-home medications (i.e., cognitive condition, inability to keep take home doses safe due to chaotic living situation). OTP program directors should work in collaboration with facility leadership to ensure that appropriate standards for infection control are maintained.

OTPs are encouraged to establish a plan to allow for continued receipt of take-home medication for those patients who report a positive test for COVID-19 or who report ILI. Options, consistent with guidance from the Centers for Disease Control, may include:

- Dispensing of medications in a separate location, minimizing contact with other Veterans and staff with appropriate infection control procedures in place. NOTE: this may be the same space designated for continuation of daily dosing for patients known to be positive for COVID-19 or presenting with ILI.

Delivery of the medication to the Veteran. When this occurs, the Veteran should be contacted in advance to arrange the delivery. When the staff person arrives at the designated location, they should call the Veteran to let them know that they have arrived. The staff member should place the medication on the doorstep and then retreat a minimum of 9 feet to observe the Veteran or designated individual picking up the medication. Upon return to the facility, staff would document delivery of the medication in the medical record. Medications must not be left unobserved. If the Veteran does not

present to pick up the medication, the staff member must retrieve the medication, return it to the facility, and document in the OTP record.

Access to Non-VA OTPs: In some facilities Veterans may be receiving medication from a Non-VA OTP. OTPs within the community are receiving similar guidance from the State Opioid Treatment Authorities. Mental Health Residential Rehabilitation Treatment Programs with Veterans who are leaving the facility daily for dosing in the community are encouraged to contact the non-VA OTP to discuss available options for take-home medications that can be safely stored at the MHRRTP limiting the need for the Veteran to go into the community. When the Veteran is admitted for a diagnosis other than OUD, methadone can also be continued as an inpatient medication (inpatient order). This option should be considered when available and clinically appropriate.

Continuity of Care: When an OTP implements procedures that significantly increases the number of Veterans receiving take home medications and/or reduces the availability of recurring psychosocial services, procedures must be in place to ensure regular contact with the Veteran. It is expected that counseling services will continue using available technology solutions.

Several guidance documents have been developed that OTP program managers may find helpful to review including information on the provision of telehealth services, including groups, via VVC as well as guidance for meeting the needs of Veterans who may be homeless or at risk for homelessness.

As local conditions change, facilities are encouraged to review any updates to existing guidance provided by VA, SAMHSA, their local State Opioid Treatment Authority, and the Drug Enforcement Administration. Specific questions about this guidance can be directed to the Substance Use Disorders Program Office within OMHSP at [redacted]@va.gov.

Attachment B

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Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum: Managing Operations of Mental Health Unit While Managing COVID-19. March 16, 2020. https://dvagov.sharepoint.com/sites/VACOVHAPublicHealth/HCI/Administration/DUSHOM%20Guidance/DUSHOM%20Memo%20dated%20031620%20subj%20Managing%20Operations%20of%20Mental%20Health%20Unit%20While%20Managing%20COVID-19.pdf

Inpatient Mental Health COVID-19 Guidance (sharepoint.com)

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Department of Veterans Affairs Memorandum. Veterans Health Administration (VHA) Masking and Screening Testing Guidance for VHA staff in Healthcare Settings. March 8, 2022. 030822--Veterans Health Administration (VHA) Masking and Screening Testing Guidance for Healthcare Settings.pdf (sharepoint.com)

Centers for Disease Control and Prevention. Types of Masks and Respirators. Masks and Respirators (cdc.gov)

ASTM International Designation: F2100-21. Standard Specification of Performance of Materials Used in Medical Face Masks. ASTM International - Standards Worldwide

VHA COVID-19 Operational Plan. VHA High Consequence Infection (HCI) Preparedness Program (sharepoint.com)

Atlanta VA Medical Center Standard Operating Procedure. COVID-19 Infection Control Guidance (rev 08.22). Effective date August 12, 2022.

Atlanta VA Medical Center Standard Operating Procedure. Employee Occupational Health COVID-19 Standard Operating Procedure. March 2, 2022.

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Atlanta VA Medical Center Standard Operating Procedure. COVID-19 Testing Guidance. December 10, 2021. Revised May 13, 2022.

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Centers for Disease Control (CDC). Guideline for Disinfection and Sterilization in Healthcare Facilities. Disinfection & Sterilization Guidelines | Guidelines Library | Infection Control | CDC

VHA Directive 1850. Environmental Programs Service. March 31, 2017.

Environmental Programs Service (EPS) Sanitation Procedure Guide. August 5, 2021. EPS Sanitation Procedure Guide | Healthcare Environment and Facilities Programs (va.gov)

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

VHA Directive 1002. Bed Management Solution (BMS) for Tracking Beds and Patient Movement Within and Across VHA Facilities. November 28, 2017.

VHA Directive 1850.02. Pest Management Operations. April 6, 2017.

Atlanta VA Medical Center. Environmental Management Service. Sanitation Procedure Guide 2019.

Atlanta VA Medical Center. Clinical Environment Surface Cleaning and Disinfecting Procedures.

Atlanta VA Medical Center Standard Operating Procedure. Cleaning of Non-Clinical Areas by Non-EMS Personnel. March 14, 2022.

Atlanta VA Medical Center. Integrated Pest Management Plan 2016.

VHA Directive 1061 Prevention of Health Care-Associated Legionella Disease and Scald Injury from Water Systems. February 16, 2021.

VHA Handbook 1160.06. Inpatient Mental Health Services. September 16, 2013.

VHA Directive 1351. Staffing Methodology for VHA Nursing Personnel. December 20, 2017.

Atlanta VA Health Care System Policy 118-45 Special Observation, October 9, 2019.

Atlanta VA Health Care System. ONPCS Policy 08-02 Staffing Methodology for Nursing, August 29, 2019.

Attachment C

Category	High (Red) Level: Operational Guidance
Care Balancing	--Use virtual appointments over in-person appointments where clinically appropriate. --Consider temporary reduction of services in inpatient surgery, inpatient admissions, outpatient procedural, and non-CLC residential care, only once contingency staffing strategies have been fully implemented. --Allow, with appropriate protections in place, in-person group care in inpatient mental health, RRTP and domiciliaries, as well as limited outpatient groups. Consider Veteran preferences, clinical benefit and infection risk when determining modality for group offerings. Continue to use existing "pods" or groups for residential settings. --Avoid cancelling appointments. Reschedule only if no alternative options. --Routinely identify, in return to clinic orders and in Consult Toolbox, future visits, consults and referrals clinically appropriate to be conducted through telehealth.
Masking & PPE	--Provide eye protection (goggles or face shield) for all patient care encounters. --Provide N95 respirators to all staff on a voluntary basis under the Mini Respiratory Protection Program. Care for COVID-19 patients requires use of N95 or above (29 C.F.R. 1910.134). --Follow CDC recommendations for use of NIOSH-approved N95 or equivalent or higher-level respirators for selected or all patient care encounters. --Enforce universal masking for all patients, staff and visitors. --Provide masks to all patients, staff and visitors. --Provide appropriate PPE to staff, optimizing supply as needed.

	--Use visual cues (signage, message boards) to explain masking requirements. --Infection Control Guidance for Healthcare Professionals about COVID-19 | CDC. --OSHA Emergency Temporary Standard.
Entry Screening	--Consider active screening at discretion of local leadership. Otherwise, allow passive15 screening. --Taking temperature is not required.
Physical Distancing	--Implement ≥6 feet physical distancing where practicable. --Consider cell phone/parking lot waiting option.
Visitors	VHA COVID-19 Visitation Quick Guide.
Testing	COVID-19 Testing Guidebook.
Workplace	--Restrict indoor in-person meetings (unless mission critical), shared meals, and gatherings. Stagger mealtimes. No restrictions on outdoor gatherings. --Maximize workplace flexibilities (i.e., telework where it does not impact operations). --Obtain USH approval for meetings >50 people. --Follow travel restrictions: Safer Federal Workforce Travel FAQs. --Follow COVID-19: VA's Workplace Re-Entry Guidance. --Follow Protecting the Federal Workforce During the COVID-19 Pandemic | SFW guidance.
Ventilation	--OSHA Ventilation. --CDC Ventilation (for health care setting); CDC Ventilation in Buildings (for non-patient care areas).
Cleaning & Disinfection	HEFP COVID Cleaning Matrix.

Key to Investigative Team Members

- [redacted] Chief Senior Medical Investigator
- [redacted] RN, Clinical Program Manager
- [redacted] Chief Nurse PCS, Behavioral Health, San Francisco VA Health Care System
- [redacted] HR Consultant, HR Center of Expertise, Workforce Management and Consulting Office
- [redacted] Program Manager, Sanitation, Environmental Programs Service, Healthcare Environment and Facilities Programs

Key to Interviewees

We interviewed the following Atlanta employees:

- [redacted] Director, Atlanta VA Health Care System
- [redacted] Deputy Associate Director, Nursing/Patient Care Services
- [redacted] Chief of Staff
- [redacted] Associate Director, Nursing/Patient Care Services
- [redacted] Associate Chief of Staff, Mental Health Service Line
- [redacted] Chief Nurse, Mental Health Nursing
- [redacted] Deputy Chief of Staff
- [redacted] Interim Chief, Quality Management
- [redacted] Chief Nurse, Nursing Operations (Resources and Staffing)
- [redacted] Deputy Chief, Office of Quality Management
- [redacted] Chief, Occupational Health/Employee Health
- [redacted] Risk Manager (Administrative Investigation Boards, Fact Findings, Institutional Disclosures)
- [redacted] Risk Manager (Tort Claims)
- [redacted] Interim Nurse Manager, Inpatient Acute Care Mental Health Unit (4Psych)
- [redacted] Clinical Psychologist, Clinical Director, Acute Mental Health Services
- [redacted] Acting Associate Chief of Staff, Rehabilitation Service Line
- [redacted] Program Manager, Infection Prevention and Control Program
- [redacted] Chief, Environmental Management Services
- [redacted] Housekeeping Aid
- [redacted] Chief, Supply Chain Management
- [redacted] Chief Engineer, Chief of Engineering Department
- [redacted] Staff Psychologist, Deputy Chief, Mental Health Service Line
- [redacted] NA
- [redacted] NA
- [redacted] Staff Psychiatrist
- [redacted] Staff Psychiatrist

- [redacted] LPN
- [redacted] LPN
- [redacted] RN
- [redacted] RN