116TH CONGRESS
1ST SESSION

S. 2995

To require the Secretary of Veterans Affairs to submit to Congress reports on patient safety and quality of care at medical centers of the Department of Veterans Affairs, and for other purposes.

IN THE SENATE OF THE UNITED STATES

DECEMBER 5, 2019

Mr. MANCHIN (for himself and Mrs. CAPITO) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

---

A BILL

To require the Secretary of Veterans Affairs to submit to Congress reports on patient safety and quality of care at medical centers of the Department of Veterans Affairs, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Improving Safety and Security for Veterans Act of 2019''.

SEC. 2. DEPARTMENT OF VETERANS AFFAIRS REPORTS ON PATIENT SAFETY AND QUALITY OF CARE.

(a) REPORT ON PATIENT SAFETY AND QUALITY OF CARE.—

(1) IN GENERAL.—Not later than 30 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report regarding the policies and procedures of the Department relating to patient safety and quality of care and the steps that the Department has taken to make improvements in patient safety and quality of care at medical centers of the Department.

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) A description of the policies and procedures of the Department and improvements made by the Department with respect to the following:

(i) How often the Department reviews or inspects patient safety at medical centers of the Department.

(ii) What triggers the aggregated review process at medical centers of the Department.

(iii) What controls the Department has in place for controlled and other high-risk substances, including the following:

(I) Access to such substances by staff.

(II) What medications are dispensed via automation.

(III) What systems are in place to ensure proper matching of the correct medication to the correct patient.

(IV) Controls of items such as medication carts and pill bottles and vials.

(V) Monitoring of the dispensing of medication within medical centers of the Department, including monitoring of unauthorized dispensing.

(iv) How the Department monitors contact between patients and employees of the Department, including how employees are monitored and tracked at medical cen-

ters of the Department when entering and exiting the room of a patient.

(v) How comprehensively the Department uses video monitoring systems in medical centers of the Department to enhance patient safety, security, and quality of care.

(vi) How the Department tracks and reports deaths at medical centers of the Department at the local level, Veterans Integrated Service Network level, and national level.

(vii) The procedures of the Department to alert local, regional, and Department-wide leadership when there is a statistically abnormal number of deaths at a medical center of the Department, including—

(I) the manner and frequency in which such alerts are made; and

(II) what is included in such an alert, such as the nature of death and where within the medical center the death occurred.

(viii) The use of root cause analyses with respect to patient deaths in medical centers of the Department, including—

(I) what threshold triggers a root cause analysis for a patient death;

(II) who conducts the root cause analysis; and

(III) how root cause analyses determine whether a patient death is suspicious or not.

(ix) What triggers a patient safety alert, including how many suspicious deaths cause a patient safety alert to be triggered.

(x) The situations in which an autopsy report is ordered for deaths at hospitals of the Department, including an identification of—

(I) when the medical examiner is called to review a patient death; and

(II) the official or officials that decide such a review is necessary.

(xi) The method for family members of a patient who died at a medical center

of the Department to request an investigation into that death.

(xii) The opportunities that exist for family members of a patient who died at a medical center of the Department to request an autopsy for that death.

(xiii) The methods in place for employees of the Department to report suspicious deaths at medical centers of the Department.

(xiv) The steps taken by the Department if an employee of the Department is suspected to be implicated in a suspicious death at a medical center of the Department, including—

(I) actions to remove or suspend that individual from patient care or temporarily reassign that individual and the speed at which that action occurs; and

(II) steps taken to ensure that other medical centers of the Department and other non-Department medical centers are aware of the suspected

role of the individual in a suspicious death.

(xv) In the case of the suspicious death of an individual while under care at a medical center of the Department, the methods used by the Department to inform the family members of that individual.

(xvi) The policy of the Department for communicating to the public when a suspicious death occurs at a medical center of the Department.

(B) A description of any additional authorities or resources needed from Congress to implement any of the actions, changes to policy, or other matters included in the report required under paragraph (1).

(b) REPORT ON DEATHS AT LOUIS A. JOHNSON MEDICAL CENTER.—

(1) IN GENERAL.—Not later than 60 days after the date on which the Attorney General indicates that any investigation or trial related to the suspicious deaths of veterans at the Louis A. Johnson VA Medical Center in Clarksburg, West Virginia (in this subsection referred to as the ''Facility''), that occurred during 2017 and 2018 has sufficiently con-

cluded, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report describing—

(A) the events that occurred during that period related to those suspicious deaths; and

(B) actions taken at the Facility and throughout the Department of Veterans Affairs to prevent any similar reoccurrence of the issues that contributed to those suspicious deaths.

(2) ELEMENTS.—The report required by paragraph (1) shall include the following:

(A) A timeline of events that occurred at the Facility relating to the suspicious deaths described in paragraph (1) beginning the moment those deaths were first determined to be suspicious, including any notifications to—

(i) leadership of the Facility;

(ii) leadership of the Veterans Integrated Service Network in which the Facility is located;

(iii) leadership at the central office of the Department; and

(iv) the Office of the Inspector General of the Department of Veterans Affairs.

(B) A description of the actions taken by leadership of the Facility, the Veterans Integrated Service Network in which the Facility is located, and the central office of the Department in response to the suspicious deaths, including responses to notifications under subparagraph (A).

(C) A description of the actions, including root cause analyses, autopsies, or other activities that were conducted after each of the suspicious deaths.

(D) A description of the changes made by the Department since the suspicious deaths to procedures to control access within medical centers of the Department to controlled and non-controlled substances to prevent harm to patients.

(E) A description of the changes made by the Department to its nationwide controlled substance and non-controlled substance policies as a result of the suspicious deaths.

(F) A description of the changes planned or made by the Department to its video surveillance at medical centers of the Department to improve patient safety and quality of care in response to the suspicious deaths.

(G) An analysis of the review of sentinel events conducted at the Facility in response to the suspicious deaths and whether that review was conducted consistent with policies and procedures of the Department.

(H) A description of the steps the Department has taken or will take to improve the monitoring of the credentials of employees of the Department to ensure the validity of those credentials, including all employees that interact with patients in the provision of medical care.

(I) A description of the steps the Department has taken or will take to monitor and mitigate the behavior of employee bad actors, including those who attempt to conceal their mistreatment of veteran patients.

(J) A description of the steps the Department has taken or will take to enhance or create new monitoring systems that—

(i) automatically collect and analyze data from medical centers of the Department and monitor for warning signs or unusual health patterns that may indicate a health safety or quality problem at a particular medical center; and

(ii) automatically share those warnings with other medical centers of the Department, relevant Veterans Integrated Service Networks, and officials of the central office of the Department.

(K) A description of the accountability actions that have been taken at the Facility to remove or discipline employees who significantly participated in the actions that contributed to the suspicious deaths.

(L) A description of the system-wide reporting process that the Department will or has implemented to ensure that relevant employees are properly reported, when applicable, to the National Practitioner Data Bank of the Department of Health and Human Services, the applicable State licensing boards, the Drug Enforcement Administration, and other relevant entities.

(M) A description of any additional authorities or resources needed from Congress to implement any of the recommendations or findings included in the report required under paragraph (1).

(N) Such other matters as the Secretary considers necessary.

○