Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Effectiveness of Actions to Correct Dental Instrument Reprocessing Deficiencies

St. Louis VA Medical Center
St. Louis, Missouri

Report No. 12-03346-270 **September 12, 2012**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to follow-up on our report, *Follow-Up Evaluation of Dental Instrument Reprocessing Deficiencies, St. Louis VA Medical Center, St. Louis, Missouri* (Report No. 10-03346-152, April 5, 2012). The purpose was to determine whether the adverse conditions identified have been resolved and whether OIG's recommendations were implemented.

In the past several months, Veterans Integrated Service Network (VISN) and facility managers have taken multiple corrective actions and many of the conditions identified in the April 2012 OIG report have been resolved. Supply Processing Service (SPS) leadership positions have been filled, SPS has moved into its fully-renovated state-of-the-art space, and communication and oversight processes are improving.

The facility has made vast improvements in its reusable medical equipment-related policies and practices over the past 6 months and the central issue of patient safety during dental procedures has been addressed. While we identified some additional improvement opportunities, facility and VISN managers have verbalized their commitment to ongoing compliance with VHA requirements. Therefore, we consider the recommendations from the April 2012 report closed.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Heartland Network (10N15)

SUBJECT: Healthcare Inspection – Effectiveness of Facility and VISN Actions to Correct Dental Instrument Reprocessing Deficiencies, St. Louis VA Medical Center, St. Louis, MO

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to follow-up on our report, *Follow-Up Evaluation of Dental Instrument Reprocessing Deficiencies, St. Louis VA Medical Center, St. Louis, Missouri* (Report No. 10-03346-152, April 5, 2012).[1] The purpose was to determine whether the adverse conditions identified have been resolved and whether OIG's recommendations were implemented.

Background

The St. Louis VA Medical Center (the facility) is a two-division, tertiary care facility in Veterans Integrated Service Network (VISN) 15. Supply Processing Service (SPS)[2] is a section of the facility that is responsible for reusable medical equipment (RME) reprocessing.

RME refers to items which are manufactured for reuse or for which the manufacturer has provided specific written reprocessing instructions. Common RME includes dental drills, probes, and retractors; endoscopes and their auxiliary parts; and surgical instruments like scissors, forceps, and scalpels. Reprocessing is the term used to encompass cleaning, disinfection, sterilization, and preparation of equipment to full readiness for its subsequent use.

In 2010, members of both the Senate and House Committees on Veterans' Affairs asked us to review allegations of deficient dental instrument reprocessing practices and related concerns at the facility. On March 7, 2011, we published our report, *Reprocessing of*

[1] http://www.va.gov/oig/pubs/VAOIG-10-03346-152.pdf
[2] SPS was previously known as Supply, Processing, and Distribution (SPD).

Dental Instruments, John Cochran Division of the St. Louis VA Medical Center, St. Louis, Missouri (Report No. 10-03346-112),[3] which found that dental RME reprocessing issues were a long-standing problem that went largely unrecognized and unaddressed by facility and VISN managers. While some corrective actions had been taken, others had not been adequately implemented. We recommended that: (1) Facility leaders monitor compliance with all appropriate elements of RME reprocessing, standard operating procedures (SOPs), staff training, and staff competencies as defined in Veterans Health Administration (VHA) guidance; (2) the VISN SPS Management Board monitors SOP compliance and currency of staff training and competencies; and (3) the VISN Director take appropriate administrative actions based on the findings of a local administrative investigation and a VHA report.

In January 2012, we returned to the facility and found that while recommendation (3) had been appropriately addressed and could be closed, recommendations (1) and (2) had not been fully implemented and many of the deficient conditions still existed. Further, while conducting a tour of the SPS area, we identified additional environmental concerns needing management attention. In our April 2012 report, we reissued original recommendations (1) and (2) related to RME reprocessing requirements and the VISN SPS Board, and included a new recommendation requiring a comprehensive baseline inspection of all SPS areas and correction of identified deficiencies.

Scope and Methodology

We visited the facility on July 24–25, 2012. Our primary focus was to determine whether actions taken in response to the April 2012 OIG report were implemented and effective, and to evaluate whether conditions had improved. We interviewed employees; reviewed employee training records and competencies, SOPs, RME manufacturers' instructions, and various committee minutes; and toured the SPS area.

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

[3] http://www.va.gov/oig/54/reports/VAOIG-10-03346-112.pdf

Inspection Results

Follow-Up to Previous OIG Recommendations

Below we list the OIG's original recommendations, the VISN and facility's initial and intended response to the recommendations, and our follow-up to determine whether the corrective actions were implemented.

April 2012 OIG Report Recommendation 1	VISN and Facility Response (Abridged)
The VISN Director requires the [facility] Director to monitor the facility's compliance with all appropriate elements of RME reprocessing, SOPs, staff training, and staff competencies as defined in relevant VHA guidance.	The facility: • audited all 1,855 SPS competencies and implemented a revised competency assessment tool to prevent further errors. • revised the RME Committee charter to enhance clinical oversight for analysis, data trending, and system monitoring to ensure implementation of sustainable actions; assigned a representative from Quality Management (QM) as co-chair of the committee; reassigned reporting requirements to the Quality Executive Board; and redefined data elements and reporting formats to include definitions, performance thresholds, and corrective and preventive action plans. • implemented the Quality Management System plan for RME to define quality control indicators and to strengthen monitoring processes. • completed a system redesign related to data and communication flow to and from the RME Committee. • initiated processes to submit RME Committee minutes to VISN leadership monthly. • continued RME Committee briefings to the Executive Board. • hired an SPS Chief, and continued recruitment efforts for other key SPS-related positions.

In July 2012, OIG Confirmed:

Since our January visit, the facility had hired a qualified SPS Chief, an RME Coordinator, and two additional SPS technicians. The new SPS Chief has also been approved to recruit for an assistant SPS Chief/supervisory technician and three more SPS technicians. These hiring actions should serve to stabilize SPS leadership and the department as a whole. We did identify opportunities for continued improvement, as follows:

- The facility had implemented a new competency assessment tool which substantially improved compliance with this requirement. However, the tracking spreadsheet listing the dates the competencies were completed did not always match the signature dates on the actual competency worksheets. For example, a

competency worksheet may have been signed by the employee and supervisor on April 5, but the tracking spreadsheet reflected an April 25 completion date.

We were told that the date reflected on the tracking spreadsheet was used as the annual competency renewal date; however, using the spreadsheet date, which was discrepant in 26 of 30 competencies we reviewed, could lead to delinquent competencies the following year.

- While the facility had modified the organization and reporting structure of the local RME Committee to improve communication of important data elements and performance thresholds, meeting minutes did not consistently reflect discussion of these items. We reviewed 6 months of RME Committee minutes (January–June 2012) and found that while SOPs were discussed during every meeting, staff competencies were not discussed until April and staff education and training was not discussed at all. Further, the minutes did not contain evidence of follow-through or completion of corrective actions in some cases. For example, the February minutes reflected a higher level of loaner trays (71, when the loaner tray rate had previously been 25). The minutes stated the action was to "drill down to compare types of cases done and loaner tray numbers" and to follow-up at the March meeting. We found no evidence in the March (or subsequent) minutes about the drill down, and no data or explanation was ever presented.

We discussed the above concerns with the facility Director who assured us that actions would be taken to update the competency spreadsheets and to improve RME Committee documentation. As the facility has made substantial improvements in the past 6 months related to RME-reprocessing activities, and the Director has assured us that improvement actions are ongoing, we consider this recommendation closed.

April 2012 OIG Report Recommendation 2	**VISN and Facility Response (Abridged)**
The VISN Director ensures that the VISN SPS Management Board monitors to ensure that SOPs are in place and staff training and competencies are current.	The VISN: • expanded the SPS Board membership to included SPS managers, Nurse Executives, QMs, Infection Preventionists, Patient Safety Managers, Chiefs of Staff, and other hospital leaders; the diversity of membership improved communication and coordination, but also limited hospital-specific discussion. • will review and modify the SPS Board charter; will assure time at each meeting for Core SPS Board members to discuss and track oversight-related issues; and will ensure oversight requirements as defined in VA directives and handbooks are covered during the Core SPS Board meeting. • will ensure SPS Board recommendations are implemented.

In July 2012, OIG Confirmed:

We reviewed VISN SPS Board minutes for January–July 2012 but did not find evidence that the Board routinely evaluated compliance with SOP, staff competency, and staff training requirements. While the Board had a spreadsheet that included the relevant data items for each VISN 15 facility, there was no documented evidence in the SPS Board minutes that missing data elements or deficient performance was discussed or that corrective action plans were initiated. None of the minutes contained any aggregate data or reference to individual facilities' compliance with SOPs, competencies, or training. Overall, the "discussions" were typically generic. For example, the May minutes state "Ensure competencies are kept up to date." This is a repeat finding from the March 2011 and April 2012 reports.

The central concern in this case was the facility's deficient RME-related policies and practices—conditions that have been largely addressed and resolved. Therefore, we could not say that the VISN SPS Board's failure to adequately document its oversight activities had a material impact on the facility. We discussed this concern with the VISN Quality Management Officer who shares responsibility for the SPS Committee and were assured that corrective actions would be implemented. We consider the recommendation closed.

April 2012 OIG Report Recommendation 3	VISN and Facility Response (Abridged)
The VISN Director requires a comprehensive baseline inspection of all SPD areas, and that identified deficiencies are promptly corrected and monitored for ongoing compliance.	The SPS area is located in temporary space until the facility finishes a $7 million renovation project due for completion in June 2012. In the interim, the facility: • conducted a thorough inspection of the area; reiterated to Environmental Management Service staff the importance of documenting cleaning activities; and reviewed with staff the policy and procedures outlining expectations. • placed tacky mats outside doorways to minimize dust and other debris entering the clean supply/storage area. • ordered an automatic door (due for installation on March 30, 2012) and placed signage to "Keep Door Closed" in an effort to maintain air pressure gradients. • covered open supply storage shelves with plastic covers. • replaced the ceiling tile that had been penetrated. • completed routine interdisciplinary Environment of Care (EOC) rounds in the SPS areas and abated all deficiencies identified in the report. • reported inspection findings to the EOC and RME committees for oversight, analysis, and ongoing monitoring.

In July 2012, OIG Confirmed:

- The state-of-the-art SPS renovation was completed ahead of schedule, and SPS operations commenced in the new area in late May 2012. (Because SPS operations have moved to the renovated space, the EOC conditions we identified related to the temporary space are no longer pertinent and are not addressed further in this report.)
- Inspections are performed monthly in accordance with guidelines and inspection reports are submitted to the appropriate oversight committees for analysis, monitoring, and corrective actions, as needed. Processes for regular cleaning and documentation thereof have substantially improved.

We consider the recommendation closed.

Conclusion

In the past several months, VISN and facility managers have taken multiple corrective actions and many of the conditions identified in the April 2012 OIG report have been resolved. SPS leadership positions have been filled, SPS has moved into its fully-renovated state-of-the-art space, and communication and oversight processes are improving. However, further actions are needed to fully resolve documentation discrepancies related to staff competencies, to assure that local RME Committee minutes consistently reflect discussion of reported deficiencies, and to assure that corrective actions are documented and followed to closure. Also, the VISN SPS Board needs to routinely evaluate compliance with SOP, staff competency, and staff training requirements.

The facility has made vast improvements in its RME-related policies and practices over the past 6 months and the central issue of patient safety during dental procedures has been addressed. While we identified some additional improvement opportunities, facility and VISN managers have verbalized their commitment to ongoing compliance with VHA requirements. Therefore, we consider the recommendations closed.

Comments

The VISN and Facility Directors concurred with our report. No further action is required.

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

Appendix A

VISN 15 Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 6, 2012

From: Director, VA Heartland Network (10N15)

Subject: Effectiveness of Facility and VISN Actions to Correct Dental Instrument Reprocessing Deficiencies, St. Louis VA Medical Center, St. Louis, Missouri

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Thru: Director, VHA Management Review Service (10A4A4)

1. I have reviewed and concur with the Effectiveness and VISN Actions to Correct Dental Instrument Reprocessing Deficiencies, St. Louis VA Medical Center, St Louis, Missouri.

2. Thank you for your review of our processes which ensures that we are continuing to provide exceptional care to our nations Veterans.

3. If you have any questions regarding the information provided, please contact Jimmie Bates, VISN 15 Quality Management Officer at 816-701-3043.

(original signed by;)
William P. Patterson, MD, MSS
Network Director VA Heartland Network (VISN 15)

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 6, 2012

From: Director, St. Louis VA Medical Center (657/00)

Subject: Effectiveness of Facility and VISN Actions to Correct Dental Instrument Reprocessing Deficiencies, St. Louis VA Medical Center, St. Louis, Missouri

To: Director, VA Heartland Network (10N15)

1. I have reviewed the report and concur with the findings and statements.

2. Thank you for recognizing the vast improvements that have been made at the VA St Louis Health Care System. These practices support the delivery of high quality and safe services to our nations Veterans.

3. Per your request, our facility point of contact is Patricia Hendrickson, RN MSN CPHQ, Director Quality Management at 314-289-7020.

(original signed by:)
RimaAnn O. Nelson RN MPH/HSA
Director, VA St Louis Health Care System (657/00)

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Toni Woodard, BS, Team Leader Kathi Shimoda, BSN Victoria Coates, LICSW, MBA

Appendix D

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