Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Dental Service Infection Control and Leadership Issues,

James J. Peters VA Medical Center
Bronx, New York

Report No. 12-01342-263

August 30, 2012

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding Dental Service at the James J. Peters VA Medical Center (facility), Bronx, NY. Specifically, it was alleged that:

- Dental Service staff ignored infection control precautions.
- The dental clinic had not had a thorough or unannounced inspection for years.
- Oral Surgery Clinic students were allowed to treat patients without direct supervision by the attending or resident staff.
- Dental Service had long been without meaningful leadership, direction, accountability, and administrative effort to maximize the quality and quantity of veteran care. Further, Dental Service leaders were indifferent and left staff unsupervised.

We did not substantiate the allegation of inadequate infection control practices. Dental residents told us that the facility's infection control requirements were stricter than those in private sector. We did not substantiate that the dental clinic had not been thoroughly inspected for years or that inspections were scripted. We did not substantiate or refute that students worked independently in the Oral Surgery Clinic. We also did not substantiate the allegations of poor or indifferent Dental Service leadership.

We found that the ratio of dental assistants to practitioners fell short of Veterans Health Administration (VHA) recommendations and impacted the work flow and patient volume handled by the clinic. Further, the low dental assistant staffing levels contributed to problems with availability, accountability, supervision, and morale. Therefore, we recommended that facility managers assess and adjust staffing ratios for dental assistants to practitioners to bring them into compliance with VHA recommendations.

The VISN Director and facility Director concurred with the findings and recommendation and provided acceptable action plans.

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

TO: Director, VA NY/NJ Veterans Healthcare Network (10N3)

SUBJECT: Healthcare Inspection – Alleged Issues with Dental Service Infection Control, Student Supervision, and Leadership, James J. Peters VA Medical Center, Bronx, New York

Purpose

VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to assess the merit of allegations regarding Dental Service at the James J. Peters VA Medical Center (facility), Bronx, NY. The purpose of the review was to determine whether the allegations had merit.

Background

The facility provides a full range of patient care services through primary care, medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. It has 241 inpatient beds, 84 community living center (CLC) beds, and 4 community-based outpatient clinics. The facility serves approximately 25,000 veterans and is part of Veterans Integrated Service Network (VISN) 3.

The Dental Clinic performs a full spectrum of dental and oral surgical procedures including general dentistry, oral surgery, endodontics,[1] periodontics,[2] and prosthodontics.[3] In fiscal year (FY) 2010, the clinic treated 4,078 unique patients. The dentists, dental assistants, dental laboratory technicians, and other dental employees report to the Service Chief. The Chief of Dental Service reports to the facility Associate Director. The dental clinic has a dependent general practice residency program through Mt. Sinai Medical Center and periodically trains third year dental students from Columbia University. At the time of our review, four general practice and two oral surgery residents were training in Dental Service.

[1] Endodontics is the diagnosis and treatment of dental pulp and root disease.
[2] Periodontics is the diagnosis and treatment of gum disease.
[3] Dental prosthodontics is the area of dentistry that focuses on the replacement of teeth and related mouth and jaw structures with artificial devices, including dentures and implants.

OIG's Hotline Division received allegations, from complainants who alleged that:

- Dental Service staff ignored infection control precautions.
- Dental Clinic had not had a thorough or unannounced inspection for years.
- Oral Surgery Clinic students were allowed to treat patients without direct supervision by the attending or resident staff.
- Dental Service had long been without meaningful leadership, direction, accountability, and administrative effort to maximize the quality and quantity of veteran care. Further, Dental Service leaders were indifferent and left staff unsupervised.

Scope and Methodology

We toured Dental Service during the January 2012 OIG CAP visit. We also conducted an unannounced site inspection on February 14–17; however, the dental clinic was closed due to accidental water damage that occurred the weekend before, and we were unable to observe dental service operations at the time. We reviewed facility and Veterans Health Administration (VHA) policies, directives, and handbooks; quality assurance documents; patient advocate reports; staff training records; meeting minutes; and other relevant documents. Prior to our site visit, we interviewed a dental consultant who is recognized as a leader in VA's infection control practices. While onsite, we interviewed Dental Service staff, residents, and other clinical and administrative staff knowledgeable about the issues.

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

Inspection Results

Issue 1: Dental Clinic Infection Control Practices

We did not substantiate the allegation that infection control practices in the dental clinic were ignored.

We found appropriate staff infection control training and annual competencies, and there was no evidence of post-procedure infections. We reviewed infection control training documentation for 24 dental employees and found 100 percent compliance with training requirements for FY 2011. We also examined the reusable medical equipment (RME) competencies for seven dental assistants, and all competencies were current for the three

pieces of dental equipment (Star Dental low speed handpiece, autoclavable[4] dental instruments and accessories, and W&H S-11[5] dental handpiece) reviewed.

For a period of 2 months, September 1–October 31, 2011, 824 patients underwent dental examinations or procedures. We reviewed the electronic health records of 30 patients and none of the records had evidence of post-procedure infections. We also interviewed, 27 dental employees, and none verbalized any egregious infection control concerns. Dental residents informed us that the VA's infection control requirements were stricter than those used by the private sector.

Issue 2: Dental Clinic Inspections

We did not substantiate that the dental clinic had not been thoroughly inspected for years or that unannounced inspections are not performed.

VHA policy requires that twice yearly the facility's inspection team conduct environment of care inspections in all patient care areas to identify and correct discrepancies, unsafe working conditions, and other regulatory violations. During our 2012 CAP inspection,[6] we confirmed that the facility conducted these rounds, and we reviewed the findings and action plans from other infection control inspections, including a 2011 Sterile Processing Service (SPS) site inspection. During the CAP inspection, we identified issues related to storage of Dental Clinic supplies and made recommendations. The Infection Preventionist[7] and Quality staff told us that unannounced inspections, such as hand washing observations, are ongoing. Several staff recalled the occurrence of external inspections of Dental Service, including 2009 site visits by The Joint Commission and VA's System-Wide Ongoing Assessment & Review Strategy teams.

Although we were unable to conduct an unannounced inspection of ongoing dental care during this site visit, evidence from the above-mentioned infection control review, our recent CAP inspection, and other inspections of Dental Service did not lend support to this allegation.

Issue 3: Oral Surgery Clinic Students

We did not substantiate that dental students were allowed to work independently in the Oral Surgery Clinic.

The complainant did not indicate a specific incident or timeframe for this allegation. The oral surgery clinic accepts two third-year dental students for a 2-week period to observe

[4] An autoclave is a machine that uses hot steam to sterilize equipment.
[5] W&H is an international company that manufactures the S-11 dental handpiece used for dental surgery.
[6] Department of Veterans Affairs Office of Inspector General, *Healthcare Inspection – Combined Assessment Program Review of the James J. Peters VA Medical Center, Bronx, NY*, Report No. 11-04566-163, April 23, 2012.
[7] An Infection Preventionist works with other disciplines to prevent healthcare-associated infection and may have held the title of "Infection Control Nurse" in the past.

surgical procedures under the supervision of residents and/or oral surgeons. Based on the 29 staff interviews and review of safety and related documents, we did not identify any incidents of dental students independently treating patients.

Issue 4: Dental Service Leadership and Accountability

We did not substantiate allegations of poor leadership and, oversight of the Dental Service.

A majority of dentists worked for the Chief of Dental Service for many years and, along with residents and facility leaders, reported satisfaction with his leadership, direction, accountability, and administrative efforts (the shortage of dental assistants being an exception). Overall, from our interviews and review of performance and other documents, we did not find evidence of questionable leadership, management, and oversight, or indifference.

Issue 5: A Shortage of Dental Assistants Exists

While not an allegation, in the course of this inspection, we identified a shortage of dental assistants.

Since July 1, 2010, VHA requires that dental RME be reprocessed in the SPS rather than in dental service areas. To comply, two facility dental assistants transport carts to the facility's SPS, located away from Dental Service, and spend most of their day tending to the RME. At the time of our visit, SPS was planning to hire additional staff to reprocess dental equipment and abate this practice for dental assistants; however, the SPS employee selection and training was still pending at the time of our review.

We determined that the dental assistant staffing level and their RME responsibilities had several ramifications. With two assigned daily to transport and decontaminate RME in the SPS, the remaining five dental assistants were assigned to assist the 15 dental practitioners, as described in the table below.[8]

Table of Dental Practitioner and Dental Assistant Staffing

Operatory	Dental Practitioners	Dental Assistants
Oral Surgery	3.6 (1.6 full time dentists and 2 residents)	1
General Dentistry (includes homeless program care and CLC)	10.4 (6.4+ full time dentists and 4 residents)	2 (floating)

[8] In addition, a part-time dentist and an expanded function dental hygienist (who functions as a program manager) work part-time in a designated operatory within the spinal cord injury unit.

New Patient	1	1
X-ray	0	1
Total	**15**	**5**

As described in a previous OIG report, VHA recommends that clinics with residency training programs have 1.5 dental assistants per dentist.[9] At the time of our report, the facility's ratio of dental assistants per dental practitioner was 0.33, well below the facility's approved staffing levels and VHA's recommended ratio. The current Chief of Dental Service was aware that a 1.5 ratio is optimal in clinics with dental residents and had made efforts to increase dental assistant staffing. In addition to informal requests, he submitted the last formal request to recruit and fill vacant dental assistant positions through the facility's Position Management Board in April 2010; however, it was not fully supported with necessary funding by the VISN.

Most Dental Service staff reported that the low staffing ratio and float assignments create problems with clinic operations and the dental assistants' availability, accountability, supervision, and morale. For example, most dental practitioners reported rarely having a dental assistant working with them; therefore, they cared for fewer patients because they were not assisted with patient preparation, care, and operatory and instrument set-up and clean-up. Some dental assistants believed that the low ratio could increase the likelihood that dental practitioners might deviate from approved infection control practices.

The dental assistants found the RME reprocessing tasks to be undesirable and beyond their job description. To compensate, the facility awarded the group and each dental assistant with a high performance rating for FY 2011. Some of the dental assistants found this to be unfair because they believed the workload was not equally distributed, carried, and performed. The rating decision also frustrated some of the dentists who were, for the first time, not invited to give input into the dental assistants' performance ratings. These reports of dissatisfaction, in part, mirrored the 2011 All Employee Survey results for Dental Service, where unfavorable responses were seen with pay satisfaction, promotion opportunities, conflict resolution, rewards, job control, and supervisory support.

Conclusions

The allegations regarding infection control practices and inspections were not substantiated from the evidence gained from interviews and document reviews. In fact, the dental residents reported that VA's infection control requirements are stricter than

[9] Department of Veterans Affairs Office of Inspector General, *Healthcare Inspection – Oversight Review of Dental Clinic Issues, Dayton VA Medical Center, Dayton, Ohio,* Report No. 10-03330-148, April 25, 2011.

those in private sector. We did not substantiate that students worked independently in the Oral Surgery Clinic. We also did not find evidence to substantiate allegations of poor Dental Service leadership.

We found that the ratio of dental assistants to practitioners fell short of VHA's recommendations and impacted the work flow and patient volume handled by the clinic. Further, the low dental assistant staffing levels contributed to problems with availability, accountability, supervision, and morale. The shortage was worsened by leave absences and a policy that requires that two dental assistants transport and reprocess RME in SPS.

Recommendation

Recommendation 1. We recommended that facility managers assess and adjust staffing ratios for dental assistants to dental practitioners to bring them into compliance with VHA recommendations.

Comments

The VISN Director and facility Director concurred with the findings and recommendation and provided acceptable action plans (see Appendixes A-C, pages 7-9, for the full text of their comments and actions.) We will follow up on the planned actions until they are completed, and we consider our recommendation closed.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 2, 2012

From: Director, VA NY/NJ Veterans Healthcare Network (10N3)

Subject: **Healthcare Inspection – Dental Service Infection Control and Leadership Issues, James J. Peters VA Medical Center, Bronx, New York**

To: Director, Baltimore Office of Healthcare Inspections (54BA)

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

Thank you for allowing me to respond to this Healthcare Inspection regarding the Dental Service Infection Control and Leadership Issues, James J. Peters VA Medical Center, Bronx, New York.

I concur with the recommendation and action plan. Should you have any questions, please do not hesitate to contact Pam Wright, RN MSN VISN3 QMO at telephone #718-741-4135.

Director, VA NY/NJ Veterans Healthcare Network (10N3)

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 27, 2012

From: Director, James J. Peters VA Medical Center (526/00)

Subject: **Healthcare Inspection – Dental Service Infection Control and Leadership Issues, James J. Peters VA Medical Center, Bronx, New York**

To: Director, VA NY/NJ Veterans Healthcare Network (10N3)

We concur with the OIG report on the allegations of Infection Control practices not been substantiated.

Based on a recent discussion with Central Office; Office of Dentistry the current staffing model provided by Central Office will be used to evaluate the appropriate staffing ratios of Dental providers and dental assistants

Director, James J. Peters VA Medical Center (526/00)

Facility Director Comments

Director's Comments to Office of Inspector General's Report

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

OIG Recommendation

We recommended that the facility managers assess and adjust the staffing ratios for dental assistants to practitioners to bring them into compliance with VHA recommendations.

Concur Implementation Date: October 11, 2012

Facility Response: Based on a recent discussion with Central Office, Office of Dentistry, the current staffing model provided by Central Office will be used to evaluate the appropriate staffing ratios of Dental providers and dental assistants.

Status: Open

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	George B. Wesley, MD Donald Braman, RN Melanie Cool, MEd, LDN Kathleen Shimoda, RN

Appendix D

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