Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Summary Report

Re-Evaluation of Reusable Medical Equipment and Environment of Care at the Central Texas Veterans Health Care System Temple, Texas

Report No. 10-03926-76

January 26, 2011

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections completed a re-evaluation of reusable medical equipment (RME) and environment of care (EOC) at the Central Texas Veterans Health Care System (the facility), Temple, TX. The purposes of the re-evaluation were to determine whether the facility had comprehensive, effective reprocessing of RME and a safe and clean health care environment.

The results of this re-evaluation indicated notable improvement in the RME and EOC areas cited for noncompliance in the Combined Assessment Program (CAP) review conducted by the OIG in March 2010. For RME, senior managers obtained a consultant to complete an organizational assessment of Supply, Processing, and Distribution and to implement improvements. Facility managers took immediate action to implement and correct many of the identified EOC deficiencies. However, further improvement is needed in both RME and EOC. We will follow up on all of the recommendations from the March CAP at the next scheduled CAP. Therefore, we made no new recommendations.

The Veterans Integrated Service Network 17 and Facility Directors concurred with our conclusions.

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

TO: Veterans Integrated Service Network 17 Director (10N17)

SUBJECT: Combined Assessment Program Summary Report – Re-Evaluation of Reusable Medical Equipment and Environment of Care at the Central Texas Veterans Health Care System, Temple, Texas

Summary

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections completed a re-evaluation of reusable medical equipment (RME) and environment of care (EOC) at the Central Texas Veterans Health Care System (the facility), Temple, TX. The purposes of the re-evaluation were to determine whether the facility had comprehensive, effective reprocessing of RME and a safe and clean health care environment.

The results of this re-evaluation indicated notable improvements in RME and EOC compared with the evaluation conducted by the OIG in March 2010. However, there were still opportunities to improve in both areas. For RME, the standard operating procedure (SOP) for the prostate biopsy probe needs to be consistent with the manufacturer's instructions, and employees need to follow the manufacturer's instructions for reprocessing colonoscopes. For EOC, we identified concerns with EOC rounds, respiratory fit testing, infection control (IC), and staff training.

Background

In March 1999, the OIG initiated Combined Assessment Program (CAP) reviews to provide recurring oversight of VA facility operations, focusing on the effectiveness and the quality of care and services provided to veterans.

In March 2010, the OIG conducted a CAP review at the facility and identified problems in RME and EOC. Inspectors had three RME findings and six EOC findings. These substantial findings initiated this re-evaluation.

Scope and Methodology

We made an announced visit to the facility November 1–3, 2010. Our review focused on RME and EOC activities over the 7-month period from March through September 2010. To evaluate RME and EOC, we interviewed the facility's Director, the Chief of Staff, selected service chiefs, and personnel. We also reviewed plans, policies, and other relevant documents. To evaluate RME, we inspected the decontamination, cleaning, and sterile storage areas within Supply, Processing, and Distribution (SPD). We also inspected the gastrointestinal (GI) reprocessing area. To evaluate EOC, we inspected patient care units, the emergency department, and outpatient clinics in Temple and Waco.

We conducted the review in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: RME

The purpose of this review was to evaluate whether the facility had processes in place to ensure effective reprocessing of RME. Improper reprocessing of RME may transmit pathogens to patients and affect the functionality of the equipment. Veterans Health Administration (VHA) facilities are responsible for minimizing patient risk and maintaining a safe environment. The facility's SPD and satellite reprocessing areas are required to meet VHA, Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration (OSHA), and Joint Commission (JC) standards.

We inspected the decontamination, cleaning, and sterile storage areas within SPD. We also inspected the GI satellite reprocessing area. We found substantial improvement overall in cleanliness. We reviewed the competency folders of 11 SPD employees and found that all annual competencies had been completed and correctly reflected manufacturers' instructions. However, we identified the following area that required continued improvement.

SOPs and Manufacturers' Instructions. VHA policy[1] requires that device-specific SOPs for RME be established in accordance with manufacturers' instructions. We reviewed the SOPs and manufacturers' instructions for five pieces of RME. We found that the SOP for the prostate biopsy probe was not consistent with the manufacturer's instructions.

[1] VHA Directive 2009-031, *Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements*, June 26, 2009.

VHA policy[2] also requires facilities to follow manufacturers' instructions when reprocessing RME. Staff did not follow the manufacturer's instructions when we observed them reprocessing the colonoscope. They did not correctly perform leak testing, which required angulations of the bending section, nor did they ensure that the colonoscope was soaked in the specified cleaning solution for the required time and at the appropriate temperature. The facility acknowledged these issues and took steps to correct them. Therefore, we made no new recommendations.

Issue 2: EOC

The purpose of this review was to determine whether the facility maintained a safe and clean health care environment. VHA facilities are required to establish a comprehensive EOC program that fully meets VHA, National Center for Patient Safety, OSHA, National Fire Protection Association, and JC standards.

Based on the recommendations made in the CAP report, the facility made changes in the Environmental Management Service (EMS), which included assigning staff permanently to specific work areas and developing an EMS response team to resolve unexpected needs. This allowed permanently assigned staff to complete routine duties as scheduled. Overall, the facility was clean, and appropriate repairs had been made. This represented a notable improvement from the previous review. The facility had corrected previous findings regarding overall cleanliness, medication security, negative air flow room monitoring, Code Alert® system monitoring, oxygen storage, intensive care unit closet floor tiles, the fire exit door, audibility of call alarms on the inpatient units, patient auditory privacy in an outpatient clinic, and external cleaning of buildings at the Waco division. However, we found the following areas still in need of improvement.

EOC Rounds. VHA policy[3] requires EOC rounds to be conducted by the facility's inspection team to allow each discipline participating to identify and correct discrepancies, unsafe working conditions, and other regulatory violations. Representation from each discipline enables the team to cover the facility in depth. VHA policy also requires specific personnel to attend EOC rounds. For the period April through September 2010, we reviewed attendance for 42 bi-weekly EOC rounds for Temple and 32 bi-weekly EOC rounds for Waco. For the Temple division, the attendance rate on rounds was 5 percent for nursing management, 83 percent for building management, 31 percent for patient safety, 69 percent for IC, and 76 percent for the Information Security Officer (ISO). For the Waco division, the attendance rate on rounds was 53 percent for the Director or Associate Director, 47 percent for nursing management, 38 percent for patient safety, 56 percent for IC, and zero percent for the ISO. These numbers indicate little improvement in this area since our March visit.

[2] VHA Directive 2009-031.
[3] Deputy Under Secretary for Health for Operations and Management, "Environmental Rounds," memorandum, March 5, 2007.

Facility management acknowledged the issue and took steps to correct it. Therefore, we made no new recommendation.

Respirator Fit Testing. OSHA requires that fit testing of any negative pressure respirator be completed at least annually for individuals identified as at risk. The facility uses N95 respirators to reduce exposure to harmful atmospheres for staff in high-risk areas. Nine (38 percent) of 24 selected direct care staff at risk for exposure did not receive the required fit testing. We noted improvement from our March visit finding and did not make a new recommendation.

IC. The JC requires the facility to monitor key IC practices and implement appropriate actions when thresholds are not met. The minutes of the IC Committee identified issues such as hand hygiene, surgical infection rates, and compliance with immunizations. For example, the hand hygiene monitor identified that 11 (29 percent) of 38 areas were below the established 95 percent threshold. There were no individualized plans based on these issues or updates to the action items when the monitors showed no improvement. This finding was the same as in our March visit. Facility management acknowledged the issue and took steps to correct it. Therefore, we made no new recommendation.

EMS Staff Training. Local policy requires EMS staff to receive annual training on cleaning and disinfection procedures. During our previous review, only 67 percent of EMS staff were compliant with required OSHA Bloodborne Pathogens Rule annual training. On this visit, all 10 of the EMS staff whose training records we reviewed had completed the required training. However, the facility was unable to provide documentation that showed that these 10 EMS staff had received annual cleaning and disinfection procedure training. This is a decrease from 28 percent from our March visit. Facility management acknowledged the issue and took steps to correct it. Therefore, we made no new recommendation.

Conclusions

We found notable improvement in the RME and EOC areas cited for noncompliance in the CAP report published July 9, 2010. Senior managers acknowledged the CAP findings and implemented several appropriate actions. Facility managers obtained a consultant to complete an organizational assessment of SPD and to implement improvements. They took action to implement and correct most of the EOC deficiencies. However, further improvement is needed in both RME and EOC. We will follow up on all of the recommendations from the March CAP at the next scheduled CAP. Therefore, we made no new recommendations.

Comments

The VISN and Facility Directors concurred with our conclusions. (See Appendixes A and B, pages 6–7, for the full text of the Directors' comments.)

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 04, 2011

From: Director, VA Heart of Texas Health Care Network (10N17)

Subject: **CAP Summary Report – Re-Evaluation of RME and EOC at the Central Texas Veterans Health Care System, Temple, Texas**

To: Director, Dallas Healthcare Inspections Division (54DA)

Director, Management Review Service (VHA CO 10B5 Staff)

1. I have reviewed the enclosed Healthcare Inspection Re-Evaluation of RME and EOC and have no additional suggestions for change.

2. VISN 17 appreciates the opportunity to demonstrate the significant improvements Central Texas has implemented since the original OIG CAP visit in March 2010.

(original signed by:)
Lawrence Biro

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 04, 2011

From: Director, Central Texas Veterans Health Care System

Subject: **CAP Summary Report – Re-Evaluation of RME and EOC at the Central Texas Veterans Health Care System, Temple, Texas**

To: Director, VA Heart of Texas Health Care Network (10N17)

1. I concur with the report. I see no changes or comments necessary.

2. For additional information, you may contact me at 254-743-2306.

(original signed by:)
Thomas C. Smith, III, FACHE

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Linda DeLong, Director Dallas Office of Healthcare Inspections
Acknowledgments	Cathleen King, Associate Director Gayle Karamanos Clarissa Reynolds Larry Ross Misti Kincaid, Program Support Assistant

Appendix D

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