Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Follow-Up Evaluation of Infection Control Deficiencies in the Dental Clinic Dayton VA Medical Center Dayton, Ohio

Report No. 10-03330-91 **February 14, 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, *Oversight Review of Dental Clinic Issues, Dayton VA Medical Center, Dayton, Ohio,* (Report No. 10-03330-148, April 25, 2011). The purpose was to determine whether the adverse conditions identified have been resolved and whether OIG's recommendations were implemented.

In the past 18 months, facility managers have taken appropriate actions and the conditions identified in the 2011 OIG report were resolved. Monitoring processes are in place to ensure ongoing compliance with standards. We consider the recommendations closed.

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

TO: Director, VA Healthcare System of Ohio (10N10)

SUBJECT: Healthcare Inspection – Follow-Up Evaluation of Infection Control Deficiencies in the Dental Clinic, Dayton VA Medical Center, Dayton, OH

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to follow-up on our report, *Oversight Review of Dental Clinic Issues, Dayton VA Medical Center, Dayton, Ohio* (Report No. 10-03330-148, April 25, 2011).[1] The purpose was to determine whether the adverse conditions identified have been resolved and whether OIG's recommendations were implemented.

Background

In 2010, members of both the Senate and House Committees on Veterans' Affairs asked us to review infection control issues in the Dayton VA Medical Center (the facility) Dental Clinic. We reviewed these issues in the report cited above. We found that a specific dentist did not comply with infection control and related procedures and that Dental Service managers were aware of these infractions prior to the initial complaint. Reviews were promptly initiated at the facility, Veterans Integrated Service Network (VISN), and VA Central Office levels. We noted that the facility followed procedures to disclose the infection control breaches to potentially affected dental patients. We confirmed that staffing levels in the Dental Clinic were suboptimal.

We recommended that the VISN 10 Director (1) review the findings related to the Dayton Dental Clinic, to include staffing issues, and take whatever action deemed appropriate, and (2) that Dental Service comply with the relevant infection control policies.

[1] http://www.va.gov/oig/54/reports/VAOIG-10-03330-148.pdf.

Scope and Methodology

We visited the facility on January 9, 2012. Our primary focus was to determine whether actions taken in response to the 2011 OIG report were implemented and effective, and to evaluate whether conditions had improved. We interviewed employees; reviewed employee training records, employee competencies, and infection control inspection reports; evaluated administrative action reports; and toured the Dental Clinic.

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.

Inspection Results

Follow-Up to Previous OIG Recommendations

The facility adequately addressed our 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.

2011 OIG Report Recommendation 1	VISN and Facility Response
The VISN 10 Director review the findings related to the Dayton Dental Clinic, to include staffing issues, and take whatever action deemed appropriate.	Modify Dental Service organizational structure and assign full-time equivalent employee levels to enhance clinical operations oversight and improve dental assistant staffing ratios. Implement actions resulting from Veterans Health Administration (VHA) National Center of Organizational Development (NCOD) Dental Service Workforce Reassessment to include the facilitation of the team building CREW (Civility, Respect, and Engagement in the Workplace) initiative. Complete administrative actions against parties responsible for appropriate infection control practices and oversight. Staffing level adjustments and personnel administrative actions are being addressed and [are] close to resolution.

In 2012, OIG Confirmed:

- Additional dental assistants have been hired. The facility has attained the accepted staffing standard of 1 dentist to 1.5 dental assistants.
- CREW sessions were initiated and are conducted on a regular basis.

- Appropriate administrative actions were taken regarding staff responsible for infection control.

2011 OIG Report Recommendation 2	VISN and Facility Response
The VISN 10 Director ensure that the Dayton Medical Center Director requires the Dental Service to comply with the relevant infection control policies.	All Dental Service mandatory infection control training will be entered and tracked for compliance in the Dayton VA Medical Center's Learning Management System (LMS). Periodic random audits of infection control training compliance, observations (e.g., hand hygiene, wearing personal protective equipment, etc.), and staff knowledge [of the] infection control checklist will be documented in the Dental Dashboard.

In 2012, OIG Confirmed:

- Managers have enforced mandatory infection control training for Dental Clinic staff; current compliance is 100 percent.
- Infection control staff conduct regular inspections (first weekly, then monthly, now quarterly) of the Dental Clinic to assure compliance with standards in the areas of environment, processes, and staff knowledge. Current compliance is at or near 100 percent.

Conclusion

In the past 18 months, facility managers have taken appropriate actions and the conditions identified in the 2011 OIG report have been resolved. Monitoring processes are in place to ensure ongoing compliance with standards. We consider the recommendations closed.

Comments

The VISN and facility Directors agreed with our report.

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

VISN 10 Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 2, 2012

From: Director, VA Healthcare System of Ohio (10N10)

Subject: Follow-Up Evaluation of Infection Control Deficiencies in the Dental Clinic, Dayton VA Medical Center, Dayton, OH

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

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

1. I have reviewed and concur with Dayton VA Medical Center's action plans and progress in comprehensively addressing and resolving the OIG's recommendations.

2. The thoroughness and professionalism of the OIG team throughout this process was appreciated and impressive. Thank you.

3. If you have questions or require additional information, please contact Jane Johnson, VISN 10 Deputy Quality Management Officer at (513) 247-4631.

(original signed by:)

Jack G. Hetrick, FACHE

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: February 2, 2012

From: Director, Dayton VA Medical Center (552/00)

Subject: Follow-Up Evaluation of Infection Control Deficiencies in the Dental Clinic, Dayton VA Medical Center, Dayton, OH

To: Director, VA Healthcare System of Ohio (10N10)

Thank you for your visit to the Dayton VA Medical Center to review our Dental Service. We appreciate the professionalism of the review team and concur with the report.

(original signed by:)

Glenn A. Costie, FACHE

Appendix A

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, Team Leader Kathi Shimoda, BSN Victoria Coates, LICSW, MBA

Appendix B

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