DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Summary Report: Evaluation of High-Risk Processes in Veterans Health Administration Facilities, Fiscal Year 2020

CHIP REPORT | REPORT #21-01509-264 | SEPTEMBER 22, 2021

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Abbreviations

CHIP	Comprehensive Healthcare Inspection Program
OIG	Office of Inspector General
SOP	standard operating procedure
RME	reusable medical equipment
SPS	Sterile Processing Services
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years. The OIG selects and evaluates specific areas of focus each year.

The purpose of this report's evaluation was to determine whether VHA facility senior managers complied with selected Sterile Processing Services (SPS) program requirements for processes related to reusable medical equipment administration, quality assurance, and staff training.

The OIG initiated unannounced inspections at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. Each inspection involved interviews with facility leaders and staff and reviews of clinical and administrative processes. The results in this report are a snapshot of VHA performance at the time of the fiscal year 2020 OIG reviews.[1] The findings in this report may help VHA identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Inspection Results

The OIG found general compliance with many of the selected requirements. However, the OIG identified weaknesses with

- standard operating procedures aligning with manufacturers' guidelines;
- annual risk analysis reporting to the Veterans Integrated Service Network SPS Management Board;
- SPS chiefs developing, implementing, and enforcing a daily cleaning schedule for all SPS areas;
- equipment storage; and[2]
- completion of Level 1 training within 90 days of hire, competency assessments for reusable medical equipment, and monthly continuing education for SPS staff.

[1] Fiscal year 2020 began October 1, 2019, and ended September 30, 2020.

[2] Equipment storage was assessed during physical inspections of 20 facilities from November 2019 through March 2020, prior to the COVID-19 pandemic. Facilities may have had more than one area inspected.

Conclusion

The OIG conducted detailed inspections at 36 VHA facilities to ensure facility staff implemented selected requirements for SPS processes. The OIG subsequently issued seven recommendations for improvement to the Under Secretary for Health in conjunction with Veterans Integrated Service Network directors and facility senior leaders. VHA leaders should use the results in this report to improve operations and clinical care at the facility level. The recommendations address findings that may eventually interfere with the delivery of quality health care.

Comments

The Deputy to the Under Secretary for Health, Performing the Delegable Duties of the Under Secretary for Health, agreed with the comprehensive healthcare inspection findings and recommendations (see appendix C, pages 16–17, and the responses within the body of the report for the full text of the executive's comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

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Purpose and Scope

The Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of randomly selected Veterans Health Administration (VHA) facilities. Comprehensive healthcare inspections are one element of the OIG's overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services. The OIG inspects each facility approximately every three years.

While the OIG selects and evaluates specific areas of focus on a rotating basis each year, the evaluation of VHA facilities' high-risk processes is an ongoing review topic because the Caregivers and Veterans Omnibus Health Services Act of 2010 designates oversight of patient care quality and safety to leaders at the national, network, and facility levels.[1] These leaders are directly accountable for program integration and communication within their level of responsibility.

The purpose of this report's evaluation was to determine whether VHA facility senior managers complied with selected Sterile Processing Services (SPS) program requirements for processes related to reusable medical equipment (RME) administration, quality assurance, and staff training.

RME includes devices or items designed by the manufacturer to be used for multiple patients after proper decontamination, sterilization, and other processing between uses. VHA requires that facilities have SPS "to ensure proper reprocessing and maintenance of critical and semi-critical reusable medical equipment"[2] The goal of SPS is to "provide safe, functional, and sterile instruments and medical devices and reduce the risk for healthcare-associated infections."[3] To ensure this, VHA requires facilities to conduct the following activities:

- Maintain a current inventory list of all RME
- Have standard operating procedures (SOPs) that are based on current manufacturers' guidelines and reviewed at least triennially
- Use CensiTrac® Instrument Tracking System for tracking reprocessed instruments[4]

[1] Public Law 111-163, Title V, Section 505.

[2] VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.

[3] Julie Jefferson, Martha Young. *APIC Text of Infection Control and Epidemiology.* Association for Professionals in Infection Control and Epidemiology, 2019. "Chapter 108: Sterile Processing."

[4] VHA Directive 1116(2); Deputy Under Secretary for Health for Operations and Management (DUSHOM) Memorandum, *Instrument Tracking Systems for Sterile Processing Services*, January 1, 2019.

- Perform annual risk analysis and report results to the Veterans Integrated Service Network (VISN) SPS Management Board
- Monitor data for reprocessing and storing RME
- Conduct annual airflow/ventilation system inspections[5]

VHA requires strict controls that closely monitor climate, storage, and sterilization parameters and additionally mandates that quality assurance documentation of this monitoring be maintained for a minimum of three years.[6] The required documentation includes high-level disinfectant solution testing, eyewash station maintenance records, and quality assurance records for RME reprocessing and sterilization.[7]

In addition, RME reprocessing areas must be clean, restricted, and airflow-controlled. All areas where RME reprocessing occurs must have safety data sheets, an unobstructed eyewash station, personal protective equipment available for immediate use, and SOPs readily available to guide the reprocessing of RME.[8]

VHA also requires facilities to provide training for staff who reprocess RME; this training must be provided and documented prior to the reprocessing of equipment. The required training includes mandatory initial competencies, continued essential staff competency assessments, and monthly continuing education. This ensures that staff have sufficient aptitude, knowledge, and skills to reprocess and sterilize RME effectively and safely.[9]

To determine whether VHA complied with OIG-selected requirements, the inspection team examined relevant documents and training records, observed reprocessing and storage areas, and interviewed key managers and staff on the following:

- Requirements for administrative processes
  - RME inventory file is current
  - SOPs are based on current manufacturers' guidelines and reviewed at least triennially
  - CensiTrac® system used

[5] VHA Directive 1116(2).

[6] VHA Directive 1116(2); VHA DUSHOM Memorandum, *Interim Guidance for Heating, Ventilation and Air Conditioning (HVAC) Requirements Related to Reusable Medical Equipment (RME) Reprocessing and Storage*, September 5, 2017.

[7] VHA Directive 1116(2); VHA Directive 7704(1), *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*, February 16, 2016.

[8] VHA Directive 1116(2).

[9] VHA Directive 1116(2).

  - Risk analysis performed and results reported to the VISN SPS Management Board
  - Airflow checks made
  - Eyewash station checked
  - Daily cleaning schedule maintained
  - Required temperature and humidity maintained
- Monitoring of quality assurance
  - High-level disinfectant solution tested
  - Bioburden tested
- Equipment storage[10]
- Completion of staff training
  - Required training completed in a timely manner
  - Competency assessments performed
  - Monthly continuing education received

The OIG initiated unannounced inspections at 36 VHA medical facilities from November 4, 2019, through September 21, 2020. Each inspection involved interviews with key staff and reviews of clinical and administrative processes. The results in this report are a snapshot of VHA performance at the time of the fiscal year 2020 OIG reviews.[11] The findings in this report may help VHA identify vulnerable areas or conditions that, if properly addressed, could improve patient safety and healthcare quality.

[10] Equipment storage was assessed during physical inspections of 20 facilities from November 2019 through March 2020, prior to the COVID-19 pandemic. A facility may have had more than one area inspected.

[11] Fiscal year 2020 began October 1, 2019, and ended September 30, 2020.

Methodology

To determine whether VHA facilities implemented and incorporated OIG-selected key quality and safety processes into local activities, the OIG interviewed senior managers and key employees and evaluated compliance with requirements for administrative processes, quality assurance, and staff training.

The OIG performed this review in conjunction with 36 comprehensive healthcare inspections of VHA medical facilities conducted during fiscal year 2020. The facilities reviewed represented a mix of size, affiliation, geographic location, and VISNs.

The OIG generated individual CHIP reports for each facility. For this report, the OIG analyzed the data from the individual facility reviews to identify system-wide trends. The OIG generally used 90 percent as the expected level of compliance for the areas discussed.

This report's recommendations for improvement target problems that can influence the quality of patient care significantly enough to warrant OIG follow-up until VHA completes corrective actions. The comments and action plans submitted by the Acting Under Secretary for Health in response to the report recommendations appear within the report.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978.[12] The OIG reviews available evidence within a specified scope and methodology and makes recommendations to VA leaders, if warranted. Findings and recommendations do not define a standard of care or establish legal liability.

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

[12] Pub. L. No. 95-452, 92 Stat 1101, as amended (codified at 5 U.S.C. App. 3).

Results and Recommendations

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care.[13] To meet this goal, VHA requires that its facilities implement programs to monitor the quality of patient care and performance improvement activities and maintain Joint Commission accreditation.[14] Many quality-related activities are informed and required by VHA directives, nationally recognized accreditation standards (such as The Joint Commission), and federal regulations. VHA strives to provide healthcare services that compare "favorably to the best of [the] private sector in measured outcomes, value, [and] efficiency."[15]

Findings and Recommendations

The OIG found general compliance with many of the selected requirements. However, the OIG identified weaknesses with

- SOPs aligning with manufacturers' guidelines;
- annual risk analysis reporting to the VISN SPS Management Board;
- SPS chiefs developing, implementing, and enforcing a daily cleaning schedule for all SPS areas;
- equipment storage; and
- completion of Level 1 training within 90 days of hire, competency assessments for RME, and monthly continuing education for SPS staff.

VHA requires that SPS chiefs ensure SOPs are based on manufacturer's guidelines and that "all SOPs are kept up-to-date, reviewed at least every 3 years and updated when there is a change in process or a change in manufacturer's IFU [instructions for use]."[16] The OIG found that 15 of 33 facilities (45 percent) that reprocessed colonoscopes used SOPs that did not align with the manufacturers' guidelines.[17] Failure to follow the manufacturers' guidelines could result in inadequate reprocessing, damage to the colonoscopes, and significant patient safety risks. Reasons for noncompliance included lack of attention to detail and oversight.

[13] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 21, 2014.

[14] VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

[15] Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence.*

[16] VHA Directive 1116(2).

[17] Three facilities reported not reprocessing the selected RME: John D. Dingell VA Medical Center (Detroit, Michigan), Tomah VA Medical Center (Wisconsin), and Tuscaloosa VA Medical Center (Alabama).

Recommendation 1

1. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain that facility staff use standard operating procedures that align with manufacturers' guidelines when reprocessing colonoscopes.

VHA concurred.

Target date for completion: March 2022

VHA response: The National Program Office for Sterile Processing (NPOSP) agrees that use of standard operating procedures (SOP) that align with manufacturers' guidelines when reprocessing colonoscopes is essential in providing the highest level of safe patient care. To make certain SOPs align with manufacturers guidelines, NPOSP will re-educate sterile processing staff and other applicable clinical staff on VHA Directive 1116(2), which states the Sterile Processing Service (SPS) Chief ensures SOPs are developed along with competency assessments for the reprocessing of all critical and semi-critical reusable medical equipment (RME), and for the operation and maintenance of equipment used in the reprocessing of critical and semi-critical RME according to manufacturer's guidelines. Education will re-enforce the guidelines and expectations for facility SPS Chiefs and staff that reprocess colonoscopes.

NPOSP will require an attestation from each Veterans Integrated Service Network (VISN) that has oversight of facilities who reprocess colonoscopes to ensure completion of staff re-education in the use of standard operating procedures that align with manufacturers' guidelines. Each VISN will provide overall compliance attestation to include an action plan for any facility that identifies as non-compliant.

VHA requires that SPS chiefs perform an annual risk analysis and "report the results to the VISN SPS Management Board."[18] The OIG found no evidence that 16 of 33 facilities (48 percent) that performed an annual risk analysis reported the results to the VISN SPS Management Board.[19] Failure to report annual risk analysis results could delay or prevent the identification of problems, process failures, and opportunities for mitigation. Reasons for noncompliance included that managers were unaware of the requirement, lack of oversight, and staffing issues.

[18] VHA Directive 1116(2).

[19] Three facilities did not complete an annual risk analysis: William S. Middleton Memorial Veterans Hospital (Madison, Wisconsin), VA Northern Indiana Health Care System (Marion), and VA Eastern Kansas Health Care System (Topeka).

Recommendation 2

2. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures Sterile Processing Services chiefs report annual risk analysis results to the Veterans Integrated Service Network Sterile Processing Services Management Board.

VHA concurred.

Target date for completion: March 2022

VHA response: The NPOSP agrees with the importance of reporting annual risk analysis results to the VISN SPS Management Board. To ensure the facility SPS Chiefs are reporting annual risk analysis results to the VISN SPS Management Board, NPOSP will re-educate sterile processing staff and facility leadership on VHA Directive 1116(2), which states the SPS Chief will perform an annual risk analysis to identify potential problems or process failures that could occur and report the results to the VISN SPS Management Board. Education will ensure SPS Chiefs are aware of these requirements.

NPOSP will require an attestation from each VISN to ensure facility SPS Chiefs are reporting the results from the annual risk analysis to the VISN SPS Management Board. An action plan will be required from each VISN that identifies non-compliant facilities.

According to VHA, SPS chiefs "must develop, implement and enforce a written daily cleaning schedule for all SPS areas."[20] The OIG found there was either no evidence of the written schedule or no evidence the schedule was followed in 7 of 36 facilities (19 percent). A written cleaning schedule helps facilities achieve and maintain a clean environment. Reasons for noncompliance included lack of oversight and attention to detail.

Recommendation 3

3. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain that Sterile Processing Services chiefs develop, implement, and enforce a written cleaning schedule for all Sterile Processing Services areas.

[20] VHA Directive 1116(2).

VHA concurred.

Target date for completion: March 2022

VHA response: The NPOSP agrees the SPS Chiefs will collaborate with Environmental Management Service (EMS) or equivalent service or department to develop, implement and enforce a written daily cleaning schedule for all SPS areas as outlined within the Environmental Services Sanitation Procedure Guide.

NPOSP will provide the appropriate education to ensure the facility SPS Chiefs develop, implement, and enforce a written daily cleaning schedule. Education will ensure SPS Chiefs are aware of these requirements.

NPOSP will require an attestation from each VISN to ensure facility SPS Chiefs have developed, implemented, and are enforcing daily cleaning schedules for all SPS areas.

An action plan will be required from each VISN that identifies non-compliant facilities.

Additionally, VHA requires high-level disinfected endoscopes to "be hung so that no part of the scope touches the bottom of the cabinet and in sufficient space for storage of multiple endoscopes without touching."[21] The OIG found that in 9 of 24 areas (38 percent) storing high-level disinfected endoscopes, equipment touched the sides or bottom of the storage cabinets.[22] Correct storage of endoscopes reduces the risk of contamination and damage to equipment. Reasons for noncompliance included lack of oversight and attention to detail.

Recommendation 4

4. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures Sterile Processing Services staff properly store high-level disinfected endoscopes.

[21] VHA Directive 1116(2).

[22] Equipment storage was assessed during physical inspections of 20 facilities from November 2019 through March 2020, prior to the COVID-19 pandemic. A facility may have had more than one area inspected. VA Illiana Health Care System (Danville, Illinois), Tomah VA Medical Center (Wisconsin), and Tuscaloosa VA Medical Center (Alabama) did not have scopes stored in SPS at the time of the inspection. Facilities that did not properly store equipment were the Charlie Norwood VA Medical Center (Augusta, Georgia), Ralph H. Johnson VA Medical Center (Charleston, South Carolina), Columbia VA Health Care System (South Carolina), Kansas City VA Medical Center (Missouri), Clement J. Zablocki VA Medical Center (Milwaukee, Wisconsin), Captain James A. Lovell Federal Health Care Center (North Chicago, Illinois), VA Eastern Kansas Health Care System (Topeka), and Robert J. Dole VA Medical Center (Wichita, Kansas).

VHA concurred.

Target date for completion: March 2022

VHA response: The NPOSP agrees with the requirement that endoscopes that have been high-level disinfected are to be hung vertically with the distal tip hanging freely in a clean, well-ventilated, dust-free area. They are to be hung so that no part of the scope touches the bottom of the cabinet and in sufficient space for storage of multiple endoscopes without touching each other.

NPOSP will provide education to ensure reprocessing staff are aware of these requirements for properly storing endoscopes. Education will re-enforce the importance to ensure all staff handling high-level disinfected endoscopes are aware of these requirements.

NPOSP will require an attestation from each VISN to ensure facilities are properly storing high-level disinfected endoscopes. An action plan will be required from each VISN that identifies non-compliant facilities.

VHA requires that "all new SPS employees must complete the SPS Level 1 training program within 90 days of hire."[23] Of the 148 selected SPS employees hired after March 23, 2016, the OIG found that 35 employees (24 percent) did not complete the training within the required time frame. Lack of timely training could result in improperly cleaned equipment. Reasons for noncompliance included lack of attention to detail and oversight.

The OIG previously identified that SPS employees who reprocessed colonoscopes at multispecialty community-based outpatient clinics did not consistently complete Level 1 training as required.[24]

Recommendation 5

5. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain that all new Sterile Processing Services employees complete Level 1 training within 90 days of hire.

[23] VHA Directive 1116(2).

[24] VA OIG, *Colonoscope Reprocessing at Multispecialty Community-Based Outpatient Clinics*, Report No. 20-01387-89, March 4, 2021.

VHA concurred.

Target date for completion: November 2021

VHA response: The NPOSP agrees that the Chief of SPS is required to ensure SPS staff members hired after March 23, 2016, complete Level 1 training within 90 days from time of appointment in SPS.

NPOSP will provide education to ensure SPS Chiefs are aware of the requirement for complete Level 1 training within 90 days of hire for SPS staff. Education will re-enforce the importance to ensure all SPS Chief and all reprocessing staff are aware and understand the importance of this requirement.

NPOSP will require an attestation from each VISN to ensure all new SPS employees complete Level 1 training within 90 days of hire. An action plan will be required from each VISN that identifies non-compliant facilities and will include a standdown for all non-compliant staff, to ensure completion.

VHA requires SPS staff who reprocess RME to complete competency assessments.[25] The OIG found that 131 of 317 selected SPS staff (41 percent) had incomplete competency assessments for reprocessing selected equipment. Failure to complete regular competency assessments could result in improper cleaning of RME and compromise patient safety. Reasons for noncompliance included lack of attention to detail and oversight and competencies did not align with SOPs or manufacturers' guidelines.

Recommendation 6

6. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, ensures that Sterile Processing Services staff complete competency assessments for reprocessing reusable medical equipment.

[25] VHA Directive 1116(2).

VHA concurred.

Target date for completion: November 2021

VHA response: The NPOSP agrees an SPS employee requires competency be assessed when an employee begins working in SPS, during the orientation period, and throughout employment in SPS.

NPOSP will provide education to ensure SPS Chiefs are aware of the requirement for competency assessment and the frequency of competency evaluations required. Education will re-enforce the importance to ensure all SPS Chief and all reprocessing staff are aware and, understand the importance of this requirement.

NPOSP will require an attestation from each VISN to ensure for all reprocessing staff, competency evaluations are completed as required. An action plan will be required from each VISN that identifies non-compliant facilities and will include a standdown for all non-compliant staff, to ensure completion.

VHA also requires that SPS staff receive monthly continuing education.[26] The OIG found that 111 of 317 selected SPS staff (35 percent) lacked evidence of at least one month of continuing education during a three-month period. Missed education could result in a knowledge gap among SPS staff. Reasons for noncompliance included lack of oversight, staffing issues, and that managers were unaware of the requirement.

The OIG previously identified that SPS staff who reprocessed colonoscopes at multispecialty community-based outpatient clinics did not consistently receive continuing education as required.[27]

Recommendation 7

7. The Under Secretary for Health, in conjunction with Veterans Integrated Service Network directors and facility senior leaders, makes certain that Sterile Processing Services staff receive monthly continuing education.

[26] VHA Directive 1116(2).

[27] VA OIG, *Colonoscope Reprocessing at Multispecialty Community-Based Outpatient Clinics*, Report No. 20-01387-89, March 4, 2021.

VHA concurred.

Target date for completion: November 2021

VHA response: The NPOSP agrees in-service education sessions focusing on the technical aspects of SPS are to be held at least once per month. SPS employees must obtain a minimum of 12 educational hours annually.

NPOSP will provide education to ensure SPS Chiefs are aware of the requirement for monthly education sessions for SPS staff. Education will re-enforce the importance to ensure all SPS Chief and all reprocessing staff are aware and, understand the importance of this requirement.

NPOSP will require an attestation from each VISN to ensure all reprocessing employees maintain the required monthly continuing education hours. An action plan will be required from each VISN that identifies non-compliant facilities and will include a standdown for all non-compliant staff, to ensure completion.

Appendix A: Comprehensive Healthcare Inspection Program Recommendations

The intent is for VHA leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues that, if left unattended, may potentially interfere with the delivery of quality health care.

Table A.1. Summary Table of Recommendations

Healthcare Processes	Requirements	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk Processes: Reusable Medical Equipment	• Administrative processes • Quality assurance • Physical inspection • Staff training	• Facility staff use SOPs that align with manufacturers' guidelines when reprocessing colonoscopes. • SPS chiefs report annual risk analysis results to the VISN SPS Management Board. • SPS chiefs develop, implement, and enforce a written cleaning schedule for all SPS areas. • SPS staff properly store high-level disinfected endoscopes. • SPS employees complete Level 1 training within 90 days of hire. • SPS staff complete competency assessments for reprocessing RME. • SPS staff receive monthly continuing education.	• None

Appendix B: Parent Facilities Inspected

Table B.1. Parent Facilities Inspected
(October 1, 2019, through September 30, 2020)

Name	City
Ann Arbor VA Medical Center	Ann Arbor, MI
Charlie Norwood VA Medical Center	Augusta, GA
Battle Creek VA Medical Center	Battle Creek, MI
Birmingham VA Medical Center	Birmingham, AL
Boise VA Medical Center	Boise, ID
Ralph H. Johnson VA Medical Center	Charleston, SC
Jesse Brown VA Medical Center	Chicago, IL
Chillicothe VA Medical Center	Chillicothe, OH
Cincinnati VA Medical Center	Cincinnati, OH
Harry S. Truman Memorial Veterans' Hospital	Columbia, MO
Columbia VA Health Care System	Columbia, SC
VA Illiana Health Care System	Danville, IL
Dayton VA Medical Center	Dayton, OH
Atlanta VA Health Care System	Decatur, GA
John D. Dingell VA Medical Center	Detroit, MI
Carl Vinson VA Medical Center	Dublin, GA
Edward Hines, Jr. VA Hospital	Hines, IL
Oscar G. Johnson VA Medical Center	Iron Mountain, MI
Kansas City VA Medical Center	Kansas City, MO
William S. Middleton Memorial Veterans Hospital	Madison, WI
Marion VA Medical Center	Marion, IL
VA Northern Indiana Health Care System	Marion, IN
Clement J. Zablocki VA Medical Center	Milwaukee, WI
Central Alabama Veterans Health Care System	Montgomery, AL
Captain James A. Lovell Federal Health Care Center	North Chicago, IL
John J. Pershing VA Medical Center	Poplar Bluff, MO
VA Portland Health Care System	Portland, OR
Roseburg VA Health Care System	Roseburg, OR
Aleda E. Lutz VA Medical Center	Saginaw, MI
VA Puget Sound Health Care System	Seattle, WA

Name	City
Mann-Grandstaff VA Medical Center	Spokane, WA
VA St. Louis Health Care System	St. Louis, MO
Tomah VA Medical Center	Tomah, WI
VA Eastern Kansas Health Care System	Topeka, KS
Tuscaloosa VA Medical Center	Tuscaloosa, AL
Robert J. Dole VA Medical Center	Wichita, KS

Source: OIG.

Appendix C: Office of the Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: September 2, 2021

From: Acting Under Secretary for Health (10)

Subj: OIG Draft Report, Comprehensive Healthcare Inspection Summary Report: Evaluation of High-Risk Processes in Veterans Health Administration Facilities, Fiscal Year 2020 (VIEWS #5739663)

To: Assistant Inspector General for Healthcare Inspections (54)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) subject draft report. The Veterans Health Administration (VHA) concurs with the recommendations and provides an action plan in the attachment.

2. VHA continues to offer a variety of collaborative efforts and trainings in support of patient safety by ensuring the Sterile Processing Service (SPS) facility staff are prepared and knowledgeable in the high-risk sterile processing practices. The National Program Office for Sterile Processing (NPOSP) continues to establish educational opportunities through a variety of mechanisms. These include VHA national monthly meetings, virtual classes and recorded trainings. During Fiscal Year 2020-2021, NPOSP provided a total of 28 classes with an average attendance of 210 VHA Staff. Additionally, in FY 2021 VHA offered a course titled, “Excellence in Scope Reprocessing” with approximately 350 VHA employees in attendance. This educational opportunity earned attendees 14.5 Continuing Educational Units.

3. The NPOSP continues to provide advanced level 2 review trainings for SPS Chiefs. In response to the COVID-19 pandemic, this training was converted from onsite to virtual. This advanced training was initially designed for SPS Chiefs and has since generated interest by other SPS staff desiring to take the class. As a result, 14 virtual level 2 trainings have been offered to all SPS staff.

4. NPOSP collaborated in the development of the VHA SPS Risk Identification, Triage, Mitigation and Sustainment (RITMS) tool, to proactively identify risks areas at the facility level. At the completion of the facility assessment, NPOSP

reviews the results and collaborates with each facility to identify and establish a process improvement plan, as indicated.

5. Comments regarding the contents of this memorandum may be directed to the GAO OIG Accountability Liaison Office at VHA10BGOALACTION@va.gov.

(Original signed by:)

Steven L. Lieberman, M.D.

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