STATEMENT OF INSPECTOR GENERAL MICHAEL J. MISSAL
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON GOVERNMENT OPERATIONS
COMMITTEE ON OVERSIGHT AND REFORM
U.S. HOUSE OF REPRESENTATIVES
HEARING ON
"ENSURING QUALITY HEALTHCARE FOR OUR VETERANS"
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Chairman Connolly, Ranking Member Meadows, and members of the Subcommittee, thank you for the opportunity to discuss the Department of Veterans Affairs (VA) Office of Inspector General's (OIG's) recent oversight of the Washington DC VA Medical Center. The mission of the OIG is to conduct effective oversight of VA's programs and operations through independent audits, inspections, reviews, and investigations. Reviews and inspections like those performed by OIG staff at the DC medical center are a vital part of our overall efforts to ensure that the nation's veterans receive high-quality and timely VA healthcare services while making the most effective use of VA resources and taxpayer dollars.

This statement summarizes the troubling findings detailed in our March 2018 report, *Critical Deficiencies at the Washington DC VA Medical Center* (the *Critical Deficiencies* report), and the results of subsequent OIG follow-up activities (both noted progress and areas requiring continued improvement).[1]

The Washington DC VA Medical Center is staffed with professionals overwhelmingly dedicated to ensuring that veterans receive high-quality health care. As previous reports detailed, the issues identified were complex and affected multiple patient care and administrative services. As the problems are longstanding, the OIG recognizes that meaningful change will take time and will ultimately be dependent on strong and stable leadership.

As of June 19, 2019, all senior leadership positions have been assumed by permanent staff. Key service chief positions have also been filled with permanent managers. Of the 40 recommendations made in the *Critical Deficiencies* report, 28 have been implemented and 12 remain open. The OIG Comprehensive

[1] *Critical Deficiencies at the Washington DC VA Medical Center*, March 7, 2018.

Healthcare Inspection Program report, published in January 2019, provided 18 additional recommendations of which one is closed.[2]

Overall, the OIG found important progress being made at the medical center. The most recent visit showed improvements in patient safety and incident reporting, reprocessing of surgical instruments and trays, Sterile Processing Service (SPS) personnel training, and staffing plans. While timely hiring actions have helped to address the known deficiencies within the Logistics and Sterile Processing services, challenges with Human Resources Management remain in addressing these critical core services, as well as other departments. Steadfast and sustainable progress hinges on leaders' vigilance and their dedication to culture change.

While the deficiencies the OIG identified were at the DC facility, they are not isolated to that medical center. OIG staff have detected some of the same problems in other facilities where oversight work is being conducted—whether lack of effective inventory management and controls, staffing shortages, challenges with specialty services like sterile processing, or routine cleanliness standards. OIG findings and recommendations should, therefore, alert other VA medical facilities what red flags to look for in regard to how weaknesses in logistics and other key systems can affect patient care and then help guide their corrective actions. OIG recommendations, if fully implemented, should also improve integrated reviews of medical facilities and oversight by Veterans Integrated Service Networks (VISNs) and the Veterans Health Administration (VHA) Central Office.[3]

PROFILE OF THE DC VA MEDICAL CENTER

The Washington DC VA Medical Center, located within VISN 5, consists of a hospital and five Community Based Outpatient Clinics. VA classifies the facility as Level 1a, the highest level of complexity for a VA hospital, which means that it provides both general and specialty surgical services.[4] The DC hospital facility served 72,868 patients in fiscal year (FY) 2017 and performed more than 3,000 surgical procedures from April 2016 through March 2017. The medical center is located within walking distance of multiple privately-owned hospitals, which have sometimes been resources for the facility.

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[2] *Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center*, January 28, 2019. The medical center provided a status update on the comprehensive health inspection recommendations several days before this hearing.

[3] VA healthcare services are delivered through 18 geographically divided administrative areas called *Veterans Integrated Services Networks*.

[4] The VHA Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3, with Level 1a facilities being the most complex and Level 3 facilities being the least complex.

TIMELINE OF RECENT WORK AT THE DC VA MEDICAL CENTER

Given the seriousness and scope of deficiencies found at the medical center, the OIG took the unusual step of issuing an interim report, a final report, and then conducting several checks on areas of particular concern. Typically, recommendations are closed within one year of an OIG report's issuance. Any interim report recommendations not yet implemented when the *Critical Deficiencies* report was issued were integrated into that report for follow-up. The timeline that follows highlights OIG oversight activities.

April 2017: Interim Report

In March 2017, in response to a confidential complaint, the OIG deployed a Rapid Response Team to conduct an inspection of the DC VA medical center. The OIG issued an interim report three weeks later that described serious conditions that put both patients and federal government assets at risk.[5] The April 2017 Interim Report identified a number of significant weaknesses at the facility, including the lack of accurate supply and equipment inventories that made it difficult to ensure patient needs were met, generally dirty conditions in clean/sterile storerooms, and millions of dollars in unaccounted for supplies and equipment.

March 2018: *Critical Deficiencies at the Washington DC VA Medical Center*

The OIG continued the inspection and reported in March 2018 on pervasive problems that presented risks to patient care and safety, service deficiencies that impeded healthcare providers' efforts, lack of control over assets, and leadership failures at multiple levels of VHA. The report also demonstrated that many management offices at VHA Central Office, VISN 5 leaders, and leaders at the medical center had been given notice of many of these documented problems, but in many cases failed to appreciate the impact on patient care to take the necessary actions to correct the problems. Significantly, the OIG did not find any patient deaths or other adverse clinical outcomes relating to these deficiencies, primarily due to the efforts of a number of committed healthcare professionals who improvised as needed to ensure veterans received the best possible care under the circumstances. The final report contained 40 recommendations addressing deficiencies in multiple core functions of the DC facility's operations—all of which were agreed to by VA.

May 2018: Rapid Response Team Follow-Up (Results Issued in January 2019 Comprehensive Healthcare Inspection Report)

In a separate but coordinated effort with an unannounced OIG Comprehensive Healthcare Inspection Program (CHIP) team (previously planned as part of a routine inspection cycle), the OIG deployed a

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[5] *Interim Summary Report - Healthcare Inspection - Patient Safety Concerns at the Washington DC VA Medical Center, Washington, DC*, April 12, 2017.

Rapid Response Team in May 2018.[6] The Rapid Response Team was sent to follow up on specific concerns related to the OIG's recommendations in the March 2018 *Critical Deficiencies* report. The team assessed the remediation status of several conditions identified in the report that could directly impact patient care and safety.

May 2018: Comprehensive Healthcare Inspection of the DC VA Medical Center (Results Issued in January 2019 Report)

The OIG conducts unannounced, triennial assessments of operations and quality control programs at VHA medical facilities and issues the findings, known as CHIP reports. These reports focus on leadership within a facility and key factors that affect patient care, such as quality, safety, and value; the credentialing and privileging process; and the environment of care. Additionally, the OIG annually rotates high-interest subtopics in areas including mental health care, women's health, high-risk processes, and medication management.[7] OIG staff may also conduct more frequent follow-ups to assess VA's progress in implementing recommendations when a facility appears unable to address OIG findings. These additional inspections help ensure issues do not remain unresolved over long periods of time. In May 2018, an OIG team was on site at the DC VA medical center to perform the CHIP review, publishing its findings in January 2019.[8]

In the review of key care processes, the OIG issued 18 recommendations for the facility Director, Chief of Staff, the Associate Director of Patient Care Services, and the Associate Director.[9]

June 2019: Follow-Up Visit by Rapid Response Team

The same OIG Rapid Response Team returned to the medical center to assess the current status of some of the more concerning findings from the *Critical Deficiencies* report. The team reviewed the following areas:[10]

- Patient safety and incident reporting

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[6] *Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center*, January 28, 2019; Appendix A: Summary Table of the OIG Rapid Response Team's Review Findings.
[7] *Semiannual Report to Congress, Issue 81*, pages 21–22.
[8] Although the OIG reviewed a spectrum of clinical and administrative processes, it is important to note that the sheer complexity of VA medical centers limits the ability for a CHIP report to assess all areas of clinical risk. The findings in the report are a snapshot of performance within the identified focus areas at the time of the OIG visit. The Rapid Response Team's follow-up review detailed above was included as Appendix A to the CHIP report.
[9] The number of recommendations should not be used as a gauge for the overall quality provided at the DC VA medical center. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care. For more on the CHIP recommendations, see Appendix A.
[10] The full results of the site visit are in Appendix B.

- Reprocessing of loaner surgical instruments and trays
- SPS staff competencies
- Staffing plans generally and Logistics and SPS staffing in particular
- Leadership and key manager vacancies

OIG RECOMMENDATION TRACKING AND FOLLOW-UP

The OIG recognizes that the recommendations made to the VHA Executive in Charge, VISN Director, and facility officials will take time to fully implement. To ensure completion, the OIG engages its centralized follow-up staff to track the implementation of all report recommendations with the responsible VA office. This consolidated function helps ensure specially trained OIG staff provide consistent management of open recommendations and facilitates timely and accurate status reporting for the website, the *Semiannual Report to Congress*, and other products that promote transparency.[11]

In response to the OIG's recommendations, the responsible VA offices provide action plans describing the process and timeline for each recommendation to be implemented. At quarterly intervals starting 90 days after report issuance, the follow-up group requests the VA office provide an accounting of actions taken to implement open recommendations, as well as whether the VA office believes a recommendation may be closed. The responsible OIG office then reviews those materials and provides a final determination as to whether any recommendations have been satisfactorily implemented and can be closed.[12] Of the 40 recommendations the OIG made in the *Critical Deficiencies* report, 12 remain open as of June 11, 2019. Additionally, 17 of the 18 recommendations in the January 2019 CHIP report remain open as the first interval of follow-up reporting is currently in process. Table 1 summarizes the 12 *Critical Deficiencies* report recommendations that have been open for more than a year. For more information on the status of all 40 report recommendations and the CHIP recommendations, see Appendix A.

[11] The OIG maintains a public recommendations dashboard that provides the real-time status of all OIG recommendations in an easy-to-access format.

[12] The responsible OIG office has the subject-matter expertise related to the recommendation at issue, and no recommendation may be closed without that office's approval. The decision to close a recommendation is based on a review of VA's supporting documentation or independent information obtained by the OIG that indicates the corrective action has occurred or progressed enough to show recommendation implementation. For example, a recommendation to train employees on a particular issue is not closed if the VA office says it will conduct the training, but rather if the VA provides syllabus and scheduling documentation showing adequately developed training is underway and will continue in a systematic fashion.

Table 1. Status of Open Recommendations from *Critical Deficiencies* Report

Recommendation	Status
1. Ensure that necessary supplies, instruments, and equipment are available in patient care areas at the medical center when and where they are needed.	The facility reports that necessary supplies, instruments, and equipment have been made available in all patient care areas consistently. However, the facility has yet to achieve full utilization of the VHA-authorized inventory system for clinical supplies. The medical center revised the action plan to reflect full implementation will not be completed until September 30, 2019.
7. Confirm the full utilization of a VHA-authorized inventory system that contains accurate and reliable information regarding the availability of supplies throughout the medical center.	The facility is reporting that the VHA-authorized inventory system is fully operational for the Medical Surgical Primary Inventory, but the Dental Primary Inventory remains in progress. The medical center revised the action plan to reflect full implementation will not be completed until September 30, 2019.
14. Ensure SPS maintains updated and readily accessible standard operating procedures for all instruments and equipment within SPS and its satellite areas.	The facility reported that SPS has been updating and maintaining readily accessible standard operating procedures for all instruments and equipment, and progress on updates is being reported monthly to its oversight committee. The facility has also instituted a process for developing standard operating procedures when new items are acquired. The revised projected completion date is June 30, 2019.
15. Verify that all SPS employees have appropriate, updated competencies and a demonstrated proficiency to perform their assigned duties.	The SPS leaders report ensuring that staff have appropriate, updated competencies and a demonstrated proficiency to perform their assigned duties. However, a key educator position became vacant in mid-March, which is impacting the SPS's ability to complete cross-training and education for all SPS staff. The medical center revised the action plan to reflect full implementation will not be completed until September 30, 2019.
19. Develop a staffing plan to fill vacancies that includes accurate numbers of authorized positions by service that is based on clinical and administrative workload and other appropriate measures, and includes contingencies for staffing areas with high attrition rates.	The facility has completed an organizational chart, a prioritized hiring list, and a staffing analysis plan. The OIG will review this recommendation for closure during the next follow-up cycle. VHA's status update is anticipated in late July 2019.
20. Ensure the timely completion of hiring actions at the medical center until staffing deficiencies in the Logistics and Sterile Processing services are fully resolved.	The Workforce Management and Consulting team assists with the timely hiring of vacant positions at the facility. While hiring actions are occurring more frequently, OIG staff believe the progress is vulnerable to stagnation or slippage. VHA has not yet requested the OIG close this recommendation.
22. Ensure that medical supply items are added to the prime vendor	The facility reports steady addition of medical supply items to the formulary and increased utilization. However, VHA

Recommendation	Status
formulary in order to meet purchasing goals.	reported that a recent major increase in products added to the Medical Surgical Prime Vendor Next Generation product list has slowed utilization rates across all medical centers, which is expected to level off in the next several months and should eventually increase compliance. The medical center revised the action plan to reflect full implementation will not be completed until June 30, 2019.
25. Update and maintain the Equipment Inventory List and hold the Medical Center Director and Chief Logistics Officer accountable for timely and accurate reporting.	The facility reported performing a wall-to-wall inventory and is rebuilding and preparing reports of its Equipment Inventory List, but it is still working to validate its quarterly inventory reports. The medical center revised the action plan to reflect full implementation will not be completed until July 31, 2019.
31. Verify that accurate and complete financial documentation to support medical supply and equipment purchases is readily available in accordance with U. S. Government Accountability Office standards.	The facility has reported progress. A recent audit by the VISN 5 Chief Logistics Officer determined the facility's Logistics Service must refine their current process to assure full compliance. The medical center revised the action plan to reflect full implementation will not be completed until September 30, 2019.
33. Ensure that the VHA Procurement and Logistics Office conducts regular audits of the Logistics services within VA medical centers to assess compliance with procurement and logistics policies and makes certain timely and effective remediation occurs in response to all noncompliant conditions identified as a result of those audits.	The Deputy Undersecretary for Health for Operations and Management oversaw each VISN's Quality Control Reviews of medical center Logistics services. At each medical center, the Facility Chief Supply Chain Officer is the contact for their action plan and the VISN Chief Logistics Officer is responsible for following up on the completion of actions. VA requested closure of this recommendation; however, the OIG requires documentation of the list of completed audits by facility.
39. The VISN 5 Director oversees implementation of recommendations directed to the Medical Center Director.	The VISN Oversight Committee continues to hold regularly scheduled calls to monitor the progress. There is also on-site verification of progress by VISN leaders and program managers. This oversight approach is to remain in place until all recommendations are closed by the OIG.
40. The Under Secretary for Health verifies the successful implementation of all recommendations contained within this report.	VHA's U.S. Government Accountability Office/OIG Accountability Liaison Team continues to review the facility's 90-day status updates, and then briefs the Executive in Charge before submitting updates to the OIG. This recommendation remains open until the successful implementation of all other recommendations.

Source: OIG quarterly follow-up database. Information is current as of June 11, 2019.

MAJOR FINDINGS IN THE OIG'S *CRITICAL DEFICIENCIES* REPORT

Service Deficiencies Affecting Patient Care

Although the medical center and VISN 5 took some steps to address the supply chain inventory management issues that made it difficult for care providers to consistently be able to readily access required supplies to meet patient needs (such as assigning additional personnel to enter data into the authorized inventory system), problems persisted following the issuance of the interim report. The OIG identified wide-ranging factors that contributed to multiple deficiencies across key services, including the following:

- Continuing supply chain and inventory management problems
- Unsafe storage of clean/sterile supplies
- Deficiencies in the SPS
- Backlogs of open and pending prosthetic consults
- Staffing shortages and human resources mismanagement
- Lack of control over assets

Supply Chain and Inventory Management Problems. The medical center was not appropriately using the required VA-authorized software program to manage the receipt, distribution, and maintenance of supplies. The problem was not new. VA's own Policy, Assistance, and Quality staff within the VHA Procurement and Logistics Office determined in its January 2017 report that the medical center did not have a VHA-authorized inventory system in place. VHA Procurement and Logistics Office staff were aware as far back as January 2016 that the medical center had reverted to its manual inventory management practices and was not using an authorized system.

On March 21, 2017, the Deputy Under Secretary for Health for Operations and Management instructed the VISN 5 Director and the Medical Center Director via an emailed memo to provide an action plan addressing the Policy, Assistance, and Quality staff's concerns. Staff were detailed to the medical center to take corrective action. Despite those efforts, the concerns were not adequately addressed, and the OIG final report provided many examples of how inventory mismanagement contributed to the lack of medical supplies being available where and when they were needed, including oxygen nasal cannula tubing, disposable surgical staplers, and tubing for blood transfusions.

The OIG continued to find ongoing inaccuracies in the data entered in the authorized inventory system at the facility. Even for a small number of items, the medical center could not reconcile its actual inventory with the data in the system. Staff's underutilization of the authorized inventory system (used for only approximately 15–25 percent of total items) meant it could not rely on the system to identify when supplies were running low or out of stock. Patient risks associated with the medical center running

out of supplies or using recalled products were heightened, and the lack of accurate stock levels contributed to urgent reordering, some overstocking, and waste of government resources.

Unsafe Storage of Clean/Sterile Supplies. To advance both patient safety and sound financial management, inventoried items must be secured and maintained in clean conditions. Proper storage of clean/sterile supplies is essential to preventing contamination and patient infections, as well as product deterioration. According to VHA directive, to maintain supplies properly, clean/sterile storerooms must have stable temperature and humidity, restricted access, weekly shelf-cleaning by Logistics Service staff, and solid bottom shelves at least eight inches from the floor. Logistics Service staff must sign a weekly log stating that the area has been checked for expired supplies, cleanliness, and damage. While Logistics Service staff have responsibility for some specific cleaning tasks in clean/sterile storerooms, the Environmental Management Service is responsible for the overall cleanliness of the rooms.

The OIG noted issues with the cleanliness of storage rooms at the facility during its team's initial inspection. While progress was noted, particularly after the facility contracted with a cleaning service, cleanliness continued to be an area of concern. Environmental Management Service and Logistics Service reported having difficulties hiring and retaining qualified staff, which made ensuring proper processes were being followed increasingly difficult. VISN 5 knew of the staffing shortages in the Environmental Management Service in early FY 2017 and knew of the Logistics Service staffing issues as early as 2014 from an external consultant's report. However, adequate steps to remedy the deficiencies were not taken.

Deficiencies in the Sterile Processing Service. The OIG detailed multiple deficiencies in the facility's SPS. These included broken and discolored instruments reaching clinical areas, incomplete surgical trays in the operating room, improper tracking and reprocessing procedures for loaner instruments, missing or expired SPS supplies, failure to follow reprocessing instructions, inadequate documentation of staff competencies, and not separating clean and dirty items in satellite reprocessing areas.

These problems were also not new. Prior reviews, dating back to at least 2015, were shared with the medical center, the VISN, and VHA Central Office that consistently revealed deficiencies in SPS processes and procedures, staffing and leadership within SPS, and environment of care concerns.[13] In response to why conditions were uncorrected for so long, SPS managers cited chronic understaffing of SPS and difficulties retaining qualified personnel.

In November 2017, the OIG received a complaint about the cancellation of nine surgeries at the medical center. The OIG confirmed the cancellations and that the medical center had reported to VHA Central Office that spotting and discoloration were found on some instruments. The *Critical Deficiencies* report

[13] The National Program Office for Sterile Processing reported concerns in April 2015, September 2015, and October 2016. The October 2016 report had 140 corrective actions including some repeat findings.

found that historically even when new instruments were purchased, they could not always be reprocessed appropriately nor were they always stored appropriately.

Backlog of Open and Pending Prosthetic Consults. VHA requires that quality patient care be provided by furnishing properly prescribed prosthetic equipment, sensory aids, and devices in an economical and timely manner. To order a prosthetic appliance or implant, a medical center provider must initiate and submit a consult (a request for an item that allows for subsequent tracking) in the electronic health record to the Prosthetics Service.

The OIG report found that the medical center and VISN 5 leaders became aware of an increasing number of open and pending prosthetic consults in May 2016 but due to incomplete administrative actions by the medical center leaders to provide access to its systems, VISN 5 could not take the necessary steps to provide assistance in addressing the increasing number of open and pending prosthetic consults.

Staffing Shortages and Human Resources Mismanagement. Medical center personnel often attributed deficiencies in the Logistics Service and SPS to chronic understaffing. The OIG determined that the Logistics Service and SPS had experienced historically high vacancy rates. A number of factors contributed to these rates, including a failure to maintain accurate data on the numbers of authorized positions throughout the medical center, the Resource Management Committee not effectively reviewing and recommending staffing requests in accordance with policy, and medical center Human Resources Management (HR) not completing hiring actions appropriately.

The OIG confirmed that high turnover rates in HR leadership may have contributed to the failure to resolve staffing issues. VHA Central Office and VISN 5 provided teams and personnel to support the medical center's general HR functions, but the DC medical center did not implement action plans developed from those consultative site visits.

Lack of Control Over Assets. The medical center mismanaged significant government resources and did not adequately secure veterans' protected information. Its financial and inventory systems produced inadequate data, lacked effective management controls, and yielded no reasonable assurance that funds were appropriately expended. A number of examples are provided in the report that show significant overpayments for particular products, unsecured access to and mismanagement of more than 500,000 items accumulated in an off-site warehouse (including purchases not meeting medical center needs, overstocked items, and some items that appeared damaged), abuse of purchase cards, and other failures to use taxpayer dollars appropriately. These include the following:

- There was excessive use of government purchase cards for medical equipment and supply purchases (89 percent of the medical center's total purchase card use was for medical supplies) instead of approved federal contracts that leverage buying power and helped ensure appropriate pricing and purchasing. Cards were misused, in part, because leaders

failed to ensure proper controls or fix the inventory system—which sometimes led to urgent purchases on purchase cards for quick delivery as a workaround for supply problems.

- A general lack of controls was found over acquisition of medical supplies and equipment, including the inability to consistently provide documentation such as purchase orders, invoices, receiving reports, or other item-level records required for proper auditing. For example, the medical center incurred nearly $875,000 in rental fees for three specialized hospital beds for patients' in-home use that could have been purchased new for a total of about $21,000.
- Because of failures in Records Management, more than 1,300 boxes of unsecured documents, including some patient protected health information and personally identifiable information were found in various locations including the off-site warehouse, on-site storage, the medical center basement, and a dumpster.

Risks to Patient Care

Functions typically thought of as administrative in nature, such as inventory mismanagement described above, can have a profound impact on the ability of healthcare providers to do their jobs effectively and reduce the risk of harm to patients. During extensive interviews conducted by the OIG's Rapid Response Team and other personnel for the *Critical Deficiencies* report, 13 healthcare providers stated that they had reported their supply, instrument, or equipment concerns to the Chief of Surgery and 12 healthcare providers stated that they had reported similar concerns to the facility's Chief of Staff. These and other issues at the facility were reported to the VISN and by VA program offices.

OIG healthcare staff independently reviewed the care provided to 124 medical center patients to determine if they experienced adverse clinical outcomes because their healthcare provider did not have the appropriate supplies, instruments, or equipment. The OIG considered an adverse clinical outcome to be death, a change in diagnosis, a change in the course of treatment, or a significant change in the patient's level of care—of which there were none identified. Staff did, however, provide examples that illustrated other impact on patients when supplies, instruments, and equipment were not available when needed. These included unnecessary anesthesia, prolonged procedures or hospitalizations, and alternative surgical techniques due to failure to ensure the availability of instruments or supplies. In some cases, procedures needed to be delayed, rescheduled, or required staff to leave the facility to borrow what was needed from a nearby private hospital. Examples include the following:

- An instrument was not sterilized since its last use and was unavailable to the surgeon after the patient received general anesthesia, resulting in the procedure being cancelled and rescheduled two days later, which unnecessarily exposed the patient to the risks associated with the anesthesia.

- Staff went "across the street" to another medical facility to acquire surgical mesh while the operation was ongoing.

The OIG found that facility staff lacked confidence that managers and leaders overseeing the facility would fix these types of problems, so they resorted to creating their own workarounds to ensure patients received proper care.

Patient Safety Reports and Follow-Up. The OIG identified failures in patient safety reporting and follow-up. Patient safety reports detail and track adverse events and "close calls" to help VA medical facilities identify and address unsafe conditions. For the interim report review, OIG staff found 193 patient safety reports since January 1, 2014, that were entered by the facility into VHA's National Center for Patient Safety database. However, OIG staff determined that the number of patient safety events was under-reported and at least 376 patient safety events related to supplies, instruments, or equipment were reported within the medical center. Of those, 206 patient safety events were entered into the facility's system but were not entered into the VHA database as required. Overall, the responsible facility staff failed to appropriately score, trend, and record patient safety events, and the medical center's patient safety manager did not properly identify that further analysis was warranted.

Within an individual medical center, the patient safety manager can identify emerging trends that could potentially compromise patient safety through event reporting and analysis. The National Center for Patient Safety analyzes data reported from all medical facilities to identify emerging trends that have the potential to compromise patient safety in multiple facilities. At the medical center, although data were available, the patient safety manager did not detect the widespread nature of the supply, instrument, and equipment problems until June 2016, when an individual root cause analysis was conducted on an incident involving the use of expired surgical supplies during a procedure.

Other facility patient safety oversight committees also failed to aggregate, describe, and track issues to resolution or to provide recommendations to medical center and VISN leaders. The OIG conducted an extensive review of meeting minutes from several committees and councils that are responsible for oversight that revealed a pattern of reporting and oversight deficits.

The OIG confirmed through interviews and analyses of documents that action plans to address patient safety, to the extent implemented, were not consistently effective at resolving issues. This was evidenced by ongoing deficiencies in many areas that affect the safety and quality of patient care. The VISN Quality Management Officer, who has responsibility for overseeing all aspects of quality management and performance improvement at VISN 5 facilities, acknowledged these concerns in an interview with OIG staff, and reported that he would be "pushing for a rapid process improvement initiative." VA reported that following the OIG findings, the medical facility cleared its backlog of patient safety incident reports.

Failures in Leadership. The OIG determined that information and documentation outlining some, if not most, of the failings in the medical center reached responsible officials in the medical center, VISN 5,

and VHA Central Office as early as 2013, but actions taken did not effectively remediate the conditions. From 2013 through 2016, the facility and VISN 5 received at least seven written reports detailing significant deficiencies in Logistics, Sterile Processing, and other services, many of which were identified as persistent at the time of the OIG 2017 visits. The chronic medical center deficiencies noted in these earlier reports spoke to leaders' inability or unwillingness at various levels to implement and sustain lasting change across multiple services.

OIG FOLLOW-UP AFTER THE *CRITICAL DEFICIENCIES* REPORT TO ASSESS PROGRESS

Following the release of the *Critical Deficiencies* report in March 2018, the OIG returned to the medical center on several occasions to spot-check conditions, receive updates, and track the facility's progress in implementing the OIG recommendations. This section highlights some of the notable progress and remaining challenges that the medical center has demonstrated or reported for the activities outlined in the timeline previously discussed:

May 2018: Rapid Response Team Follow-Up (Results Issued in January 2019 Comprehensive Healthcare Inspection Report)

While all of the report's recommendations are tracked quarterly in accordance with OIG follow-up practices, the OIG Rapid Response Team focused on spot-checking the areas of concern that could directly impact patient care and safety.

The team inspected clean/sterile storerooms and other supply storage areas; interviewed clinicians, managers, and facility leaders; reviewed facility policies, meeting minutes, quality management documents, competency data, and consult information; and evaluated facility staffing and other HR-related activities. The team also reviewed several patients' electronic health records to assess quality of care.

The team found substantial improvements in some previously deficient areas and minimal improvement in others. In most areas reviewed, however, the OIG found that corrective actions had thus far resulted in moderate improvements. Because less than three months had elapsed from the release date of the March 2018 *Critical Deficiencies* report to this site visit, the team focused on determining whether efforts seemed to be heading in the right direction or appeared stalled. The team found several examples of the facility leaders' compliance and corrective actions.

Substantial Improvements in Availability of Supplies and Prosthetic Consults. The *Critical Deficiencies* report referenced examples in which patients were put at risk because of the lack of immediate access to supplies. These included the unavailability of laparoscope testing supplies, dialysis bloodlines, oxygen nasal tubing, and other significant items. That report further noted that "[o]f 30 healthcare providers interviewed, at least 24 reported having had problems with supplies, instruments, or equipment." In late May 2018, 50 of 55 (91 percent) clinicians and managers interviewed by OIG team

members said that the availability of supplies had improved. Further, the team found adequate stock of some previously reported shortages.

The *Critical Deficiencies* report also noted that more than 10,000 prosthetic consults were open or pending as of March 31, 2017. As of May 23, 2018, the backlog of prosthetic consults had been reported as eliminated. No prosthetic consults were pending 30 days or more. There were 461 pending prosthetic consults, of which 372 were pending 0–5 days, 76 were pending 6–9 days, and 13 were pending 10–29 days. The medical center was able to achieve these results by hiring a permanent service chief; nearly doubling the Prosthetics Service staff; and rearranging the way in which incoming consults were reviewed, worked, and dispositioned. The OIG closed the recommendation on prosthetic consults based on the demonstrated progress.

Minimal Improvements in Patient Safety Processes, Sterile Processing, and Human Resources. The OIG had previously identified problems with underscoring and underreporting patient safety events, which resulted in missed opportunities to perform root cause analyses and other prevention or remediation actions. The OIG team found during its May 2018 site visit that 416 of 419 (99 percent) patient safety events were scored as a 1 (lowest severity). However, the OIG identified four events that were scored as a 1 that the team felt warranted a severity score of 2. While in three instances, the patients may not have experienced adverse clinical outcomes, systems issues were present that warranted further facility review. In the fourth case, the patient's provider did not order anticoagulant medication after a coronary artery bypass graft surgery. One week later, the patient was readmitted to the facility with a diagnosis of pulmonary embolism—a life-threatening condition that could have been related to the lack of the appropriate anticoagulation medication. The OIG team notified the medical center's Quality Manager about this patient and the possible need for further evaluation.

Multiple problems with SPS staff's competencies were reported previously that included expired or undated competencies, lack of documentation regarding required training, and competencies not consistently updated to keep pace with manufacturer's issuance of instructions. The OIG Rapid Response Team noted during its May 2018 site visit that SPS standard operating procedures and competencies were under review and were being incorporated into the competency grids following approval. While SPS competencies were a work in progress, the process appeared to be more organized and compliant with VHA policy. During a follow-up contact with SPS leaders in August 2018, the OIG was also told that its loaner instrument tracking system had been implemented and progress made; however, some staff were still using a paper log to track loaner instruments.

High turnover rates in HR leadership was also previously found to have contributed to the failures to resolve a variety of issues. From January 2012 through July 2017, the facility had 10 HR Chiefs in a combination of acting and permanent capacities. By late May 2018, the acting Medical Center Director still described the HR department as his most "problematic" service. The VISN 5 HR Officer was detailed as the facility's HR Chief, but reportedly, two of the three HR supervisor positions were vacant.

At the time of the May 2018 OIG site visit, the organizational charts with proposed positions had also still not been completed, although due on the last day of the OIG's spot inspection.

Status of Remaining Recommendations during May 2018 Rapid Response Team Visit. The facility was taking reasonable actions to address the remaining open recommendations. In most areas, conditions appeared to be improving. For example, staffing had improved in Logistics, relevant committees had reengaged, and processes appeared to be focused on fixing the problems rather than responding to crises. However, as many of the problems and corrective actions are complex, it was clear that more work and time would be needed to gauge progress and the sustainability of improvements for the remaining OIG *Critical Deficiencies* recommendations.

May 2018: Comprehensive Healthcare Inspection of the DC VA Medical Center (Results Issued in January 2019 Report)

Quality, Safety, and Value. The OIG found a general lack of consistent processes for the identification of opportunities for improvement; implementation of recommended actions; and evaluation of effectiveness of actions taken with utilization management, patient safety, and root cause analysis processes. Thus, the OIG identified deficiencies in protected peer reviews, utilization management, and patient safety that warranted recommendations for improvement. The protected peer review deficiency represents a repeat finding from the OIG's June 2014 Combined Assessment Program review.[14]

Credentialing and Privileging. The OIG found general compliance with requirements for credentialing and privileging of care providers. However, the OIG identified deficiencies in using evidence from Focused and Ongoing Professional Practice Evaluations to determine continuation of privileges.

Environment of Care. The OIG noted privacy measures were in place at the facility and a Community Based Outpatient Clinic. The OIG did not detect any issues with emergency management processes. The OIG noted some deficiencies in infection prevention, environmental cleanliness, sterile supplies, medical equipment safety, and mental health seclusion room safety.

Medication Management. The OIG found that prior to January 2018, the controlled substances program was not compliant with VHA requirements. A new Coordinator and alternate Coordinator were assigned in January 2018, and the OIG found that improvements were evident starting in February 2018, with general compliance noted with requirements for Coordinators' reports, Coordinators' and Inspectors' completion of required training, and pharmacy inspections. However, the OIG found several additional deficiencies including not reconciling stock returned to the pharmacy.

[14] *Combined Assessment Program Review of the Washington DC VA Medical Center, Washington, DC*, August 1, 2014.

Long-Term Care. The OIG noted compliance with the provision or access to geriatric evaluation, provision of care, development of plans of care, and implementation of interventions in plans of care when indicated. However, the OIG identified a deficiency in program oversight.

High-Risk Processes. The OIG noted compliance with the presence of a policy for use and care of central lines, annual risk assessment, review and discussion of central line-associated bloodstream infection data, patient education, and use of a checklist. However, the OIG identified a deficiency in staff education.

Incidental Finding on Patient Report Backlog and Facility Response. The OIG found that 1,550 inches of patient reports dating back to 2014 had not been scanned into the electronic health records. This caused patient results within these records to not be available to healthcare providers. As of the May 2018 OIG visit, the contractors were apparently still unable to access the electronic health record system to commence document scanning.

The Acting VISN Director and Acting Facility Director agreed with the CHIP review findings and 18 recommendations and provided acceptable improvement plans. The OIG considered recommendation 14 closed at the time of report publication, which related to the duties of the Controlled Substance Coordinator and Alternate Controlled Substance Coordinator being properly included in the employees' position descriptions (or functional statements).

VHA submitted its first status update response on June 17, 2019. With an implementation closing date VHA set for June 30, 2019, or earlier for all report recommendations, it requested closure of four of the 18 recommendations in its status update response. The OIG review team has not agreed to close any of these four recommendations. The OIG will continue to monitor VHA's progress in fully implementing the recommendations. For more information on the status of all 18 CHIP recommendations, see Appendix A.

June 2019 Follow-Up Findings

Overall, the OIG team determined that conditions in the five areas reviewed had improved and leaders and managers were taking steps to change the facility's culture and strengthen elements of the medical center's infrastructure for select systems. Leaders and managers are also enhancing policies and procedures, and implementing monitoring and oversight processes.

Signs of progress included the following:

- **Patient Safety and Incident Reporting (Recommendation 5):** VISN staff are conducting quarterly audits that include a review of staff compliance with Safety Assessment Code scoring requirements for all reported patient safety events. While the OIG previously closed this recommendation, this check confirms that the facility and VISN have continued to perform the required internal oversight.

- **Reprocessing Loaner Surgical Instruments and Trays (Recommendation 12):** SPS and operating room staff are consistently using the electronic loaner instrument tracking system. Policies and procedures for the proper reprocessing of loaner instruments and trays have been developed and staff received training on those policies and procedures. Reprocessing of loaner instruments and trays is audited through the quality assurance process to ensure proper procedures are followed.
- **SPS Staff Competencies (Recommendation 15):** Sampled documentation of employee competencies pertaining to sterile processing duties met VHA requirements.
- **Logistics and SPS Staffing (Recommendation 20):** The medical center has increased the number of authorized Logistics staff positions from 60 to 74. Of those 74 positions, 52 had been filled and another 20 were filled through contracted staff. The facility Director recognized the need to monitor Logistics staffing closely. Of the 36 authorized SPS staff positions, 27 have been filled. SPS filled an additional seven positions through contracted staff. The OIG continues to monitor SPS staffing given the time it has taken to address the critical staffing deficiencies from 2017.

The OIG team cautioned that continued vigilance would be needed to maintain improvements. For more information, see Appendix B for the full summary of the OIG's June 2019 follow-up visit to the medical center.

Ongoing OIG Follow-Up

The OIG will continue to monitor the remaining open recommendations from the *Critical Deficiencies* and CHIP reports until all have been closed. In addition, the OIG has a number of projects and initiatives that have flowed, in part, from the issues that were identified as part of the oversight work at the medical center. Among these efforts are the following:

- The OIG is expanding its CHIP work to focus on VISN-level leadership in a more systematic way. There is limited utility to having medical facilities implement recommendations if those corrective actions are not supported by the VISN. This expanded focus on VISNs is meant to address the oversight and services that VISNs provide all medical centers within their network that affect efficient operations and quality patient care. After completing several successful pilot visits, the OIG will be conducting unannounced reviews of four VISNs during the remainder of FY 2019. OIG staff conducting facility- and VISN-level inspections are engaging in coordination efforts to ensure reports regarding medical facilities make relevant connections to their VISN responsible for leadership, support, and oversight. The reports will include recommendations to improve accountability for the provision of high-quality health care.

- Reviews are planned to assess the financial management and logistics processes within multiple VA medical centers to ensure VHA is implementing prudent financial practices and effectively managing its funds, programs, and resources. These financial reviews are intended to assist VHA in their efforts to identify potential high-risk issues or areas and mitigate those risks. OIG staff will make recommendations to the medical centers to help improve operations and systems that affect the timely and quality care to veterans.
- The OIG Office of Audits and Evaluations (OAE) is conducting work to determine whether VHA effectively uses the National Surgery Office operating room efficiency data to identify and address underlying infrastructure problems. If used effectively, the data can help to address persistent and serious surgical infrastructure problems such as untimely arrivals of surgeons, anesthesiologists and nurses for surgeries; unsterile or missing surgical equipment or supplies; and lack of prompt operating room cleaning.
- OAE is also conducting an audit to determine whether VHA has the appropriate controls in place to verify when veterans receive prosthetic supplies shipped by vendors, or to prevent shipment of supplies to veterans who died following their purchase.
- Another audit is underway to determine whether VA adequately monitors order fulfillment and performance reporting to ensure the timely and complete shipment of Medical Surgical Prime Vendor Next Generation (MSPV-NG) supplies. The MSPV-NG is VA's national program for procuring medical surgical supplies across VHA. In 2018, VA spent approximately 30 percent ($450 million) of all medical and surgical supply dollars via four MSPV-NG contracts valued at $4.6 billion. These contracts are critical to ensuring supplies are provided in a timely fashion and in the right quantity for effective care.
- The OIG recently issued a report that assessed VHA's oversight of its medical centers' migration from the Catamaran inventory management system to the Generic Inventory Package and determined whether medical centers accurately managed expendable supply inventories.[15] The findings include (1) VA medical centers encountered challenges migrating to the Generic Inventory Package, (2) significant discrepancies existed in Generic Inventory Package inventory data for expendable medical supplies, and (3) proper inventory monitoring and management was lacking at many medical centers. While some of the issues stemmed from VHA and VISN failure to provide adequate oversight of the migration, the OIG also identified other factors that caused inventory data inaccuracies, including inaccurate or lacking inventory management practices.

[15] *Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package*, May 1, 2019.

CONCLUSION

The OIG has conducted significant oversight of the Washington DC VA Medical Center's progress on implementing recommendations to improve conditions, operations, and systems that will improve the quality of care for its patients. We commend the efforts of every staff member, manager, and leader who has worked to make those improvements. While there are still considerable challenges ahead, many persistent problems are being addressed and personnel are moving in the right direction.

The OIG remains vigilant by carefully monitoring any complaints that come to our Hotline related to the facility. In addition, OIG staff are continuously engaged with staff and leaders from the facility, VISN, and VHA Central Office through our follow-up process. This engagement allows OIG personnel to closely review their progress in implementing the remaining open recommendations. Changing a culture that has allowed problems to persist for such long periods is not easy and will require the unrelenting focus and energy of VA employees and leaders. The OIG will continue to monitor the advancements made at the facility and remain alert to signs that progress is being stymied or unsustained.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you and other members of the Subcommittee may have.

APPENDIX A: STATUS OF RECOMMENDATIONS IN THE *CRITICAL DEFICIENCIES* AND WASHINGTON DC VA MEDICAL CENTER CHIP REPORTS

Table 1.A. Status of All Recommendations from *Critical Deficiencies at the Washington DC VA Medical Center* (Report #17-02644-130, Issued March 7, 2018)

Recommendation	Open (VA's Expected Closure Date)	Closed (Closure Date)
1. The Medical Center Director ensures that necessary supplies, instruments, and equipment are available in patient care areas at the Medical Center when and where they are needed.	September 30, 2019	
2. The Medical Center Director requires operating room staff to conduct the final validation that all supplies, instruments, and equipment needed to perform the planned procedure and to address potential complications are in the operating room and available for use.		April 19, 2019
3. The Medical Center Director makes certain that the operating room staff have accurate lists of surgical instruments needed for particular procedures.		April 19, 2019
4. The Under Secretary for Health specifies criteria under which individual medical centers will conduct wild card Aggregated Reviews for high-frequency patient safety events.		April 8, 2019
5. The Medical Center Director ensures that routine audits of incident reporting system entries are completed to ascertain that all patient safety events are in the National Center for Patient Safety database as required by Veterans Health Administration policy.		January 9, 2019
6. The Medical Center Director requires Medical Center oversight committees to follow up and initiate action as necessary on quality assurance matters related to supplies, instruments, or equipment.		May 10, 2019
7. The Medical Center Director confirms the full utilization of a Veterans Health Administration-authorized inventory system that contains accurate and reliable information regarding the availability of supplies throughout the Medical Center.	September 30, 2019	
8. The Medical Center Director makes certain that the environmental integrity of clean/sterile storerooms complies with Veterans Health Administration policy.		January 9, 2019

Recommendation	Open (VA's Expected Closure Date)	Closed (Closure Date)
9. The Medical Center Director ensures there are clearly defined and effective procedures for replacing missing or broken instruments, and that staff responsible for this function have been educated on the process.		May 8, 2019
10. The Medical Center Director confirms that clearly defined and effective procedures address the disposition of discolored instruments during reprocessing and that staff responsible for this function have been educated on the process.		May 10, 2019
11. The Medical Center Director ensures that the Sterile Processing Service implements a quality assurance program to verify the cleanliness, functionality, and completeness of instrument sets prior to their reaching clinical areas.		May 10, 2019
12. The Medical Center Director makes certain that Sterile Processing Service and operating room personnel comply with policies and procedures for the proper reprocessing of loaner instruments and trays.		April 28, 2019
13. The Medical Center Director verifies that Sterile Processing Service managers maintain an accurate Master List for reusable medical equipment and file copies of manufacturer's instructions as required by Veterans Health Administration policy.		October 10, 2018
14. The Medical Center Director ensures that the Sterile Processing Service maintains updated and readily accessible standard operating procedures for all instruments and equipment within Sterile Processing Service and its satellite areas in accordance with Veterans Health Administration policy.	June 30, 2019	
15. The Medical Center Director verifies that all Sterile Processing Service employees have appropriate, updated competencies and a demonstrated proficiency to perform their assigned duties.	September 30, 2019	
16. The Veterans Integrated Service Network 5 Director secures adequate space and funding for the Medical Center satellite reprocessing areas, which includes separate decontamination, processing, and packaging areas in accordance with Veterans Health Administration Sterile Processing Service policies.		January 9, 2019
17. The Veterans Integrated Service Network 5 Director makes certain that the Medical Center Director resolves		July 13, 2018

Recommendation	Open (VA's Expected Closure Date)	Closed (Closure Date)
open and pending prosthetic consults and implements a plan to address future prosthetic consults in accordance with Veterans Health Administration policy.		
18. The Medical Center Director ensures the revision of Medical Center Fiscal Service practices to eliminate unnecessary cessations of prosthetic device purchasing, including at fiscal year-end.		October 10, 2018
19. The Veterans Integrated Service Network 5 Director, together with Medical Center leaders, develops a staffing plan to fill vacancies that includes accurate numbers of authorized positions by service that is based on clinical and administrative workload and other appropriate measures, and includes contingencies for staffing areas with high attrition rates.	April 30, 2019	
20. The Veterans Integrated Service Network 5 Director ensures the timely completion of hiring actions at the Medical Center until staffing deficiencies in Logistics Service and Sterile Processing Service are fully resolved.	April 30, 2019	
21. The Medical Center Director transitions purchase cards held by clinical staff and used for expendable medical supplies to Logistics Service staff, while ensuring that medical supplies can be obtained in a timely manner.		January 25, 2019
22. The Medical Center Director ensures that medical supply items are added to the prime vendor formulary in order to meet prime vendor purchasing goals.	June 30, 2019	
23. The Medical Center Director makes certain that the Purchase Card Coordinator and approving officials monitor the issuance and future use of government purchase cards in accordance with VA Financial Policy.		January 25, 2019
24. The Medical Center Director maintains segregation of duties between personnel who order and purchase expendable and nonexpendable items and those who receive the items.		August 16, 2018
25. The Veterans Integrated Service Network 5 Director ensures that the Medical Center updates and maintains the Equipment Inventory List as required by VA policy and makes certain that the Medical Center Director and Chief Logistics Officer are held accountable for the timely and accurate reporting of the Medical Center Equipment Inventory List.	July 31, 2019	

Recommendation	Open (VA's Expected Closure Date)	Closed (Closure Date)
26. The Medical Center Director ensures that equipment is accurately and timely entered into the Automated Engineering Management System/Medical Equipment Reporting System.		October 10, 2018
27. The Medical Center Director ensures that unrequired equipment is turned in for disposition consistent with Veterans Health Administration policies and procedures.		January 18, 2019
28. The Medical Center Director properly secures all areas used to store medical equipment and supplies.		October 10, 2018
29. The Medical Center Director designates an official records manager, alternate records manager, and official records liaisons, as well as implements a records management program in accordance with the National Archives and Records Administration requirements.		April 19, 2019
30. The Medical Center Director verifies that actions have been taken to notify patients when their information may have been improperly accessed, as appropriate.		October 10, 2018
31. The Medical Center Director verifies that accurate and complete financial documentation to support medical supply and equipment purchases is readily available in accordance with U. S. Government Accountability Office Standards for Internal Control in the Federal Government.	September 30, 2019	
32. The Veterans Integrated Service Network 5 Director audits a representative sample of fiscal year 2017 Medical Center supply, instrument, and equipment purchases and ensures adequate internal controls for future purchases are in place.		April 15, 2019
33. The Deputy Under Secretary for Health for Operations and Management ensures that the Veterans Health Administration Procurement and Logistics Office conducts regular audits of the Logistics Services within Veterans Health Administration medical centers to assess compliance with VA and Veterans Health Administration policies pertaining to procurement and logistics, and makes certain that timely and effective remediation occurs in response to all noncompliant conditions identified as a result of those audits.	March 31, 2019	
34. The Veterans Integrated Service Network 5 Director evaluates the accuracy of representations made by Medical Center staff in connection with the completion of action plans arising out of the National Program Office of Sterile		October 10, 2018

Recommendation	Open (VA's Expected Closure Date)	Closed (Closure Date)
Processing October 2016 site visit and determines whether administrative actions should be taken as a result of those representations.		
35. The Veterans Integrated Service Network 5 Director institutes procedures designed to ensure the accuracy of future representations made by Washington DC VA Medical Center staff in connection with action plans submitted to oversight bodies such as Veterans Health Administration program offices.		June 5, 2019
36. The Under Secretary for Health clearly defines program offices' responsibility for reporting high-priority recommendations to responsible individuals within the Veterans Health Administration Central Office, and requires independent verification that the relevant medical center and/or VISN have implemented the recommendations.		January 9, 2019
37. The Under Secretary for Health develops a means of aggregating and analyzing available data on Logistics, Sterile Processing, Prosthetics, and Human Resources services (or other services as the Under Secretary for Health deems appropriate) so that major operational deficiencies at a medical center or Veterans Integrated Service Network that affect multiple services or functions may be detected and corrected.		October 22, 2018
38. The Under Secretary for Health takes appropriate administrative action to address the conditions identified in this report.		April 24, 2019
39. The Veterans Integrated Service Network 5 Director oversees implementation of recommendations directed to the Medical Center Director.	October 31, 2019	
40. The Under Secretary for Health verifies the successful implementation of all recommendations contained within this report.	October 31, 2019	

Source: OIG quarterly follow-up database. Information is current as of June 11, 2019.

Table 1.B. Status of All Recommendations from *Comprehensive Healthcare Inspection Program Review of the Washington DC VA Medical Center* (Report #17-01757-50, Issued January 28, 2019)

Recommendation	Open (VA's Expected Closure Date)	Closed (Closure Date)
1. The Facility Director ensures that recommended actions from peer reviews and root cause analyses are implemented and monitored for improvement.	June 30, 2019	
2. The Chief of Staff ensures that assigned staff complete at least 75 percent of all inpatient admissions and continued stay reviews and monitors the staff's compliance.	June 30, 2019	
3. The Chief of Staff ensures an interdisciplinary facility group reviews utilization management data and monitors the group's compliance.	June 30, 2019	
4. The Facility Director ensures that the Patient Safety Manager provides feedback of root cause analysis results to the reporting individuals or departments and monitors compliance.	June 30, 2019	
5. The Chief of Staff ensures that Focused and Ongoing Professional Practice Evaluations are completed, and that the Professional Standards Board reviews these evaluations in considering whether to continue provider privileges, and monitors compliance.	June 30, 2019	
6. The Associate Director ensures that safety and infection prevention processes are in place at construction sites and monitors compliance.	June 30, 2019	
7. The Associate Director for Patient Care Services ensures that nursing staff dispose of expired or unsealed supplies and monitors the staff's compliance.	June 30, 2019	
8. The Associate Director ensures that a safe and clean environment is maintained throughout the facility and monitors compliance.	March 31, 2019	
9. The Associate Director ensures all applicable equipment is inspected and identified as safe for patient use and monitors compliance.	March 31, 2019	
10. Associate Director ensures the mental health seclusion room flooring provides cushioning.	January 31, 2019	
11. The Associate Director ensures the furniture in the mental health seclusion room is limited to an appropriate style bed and monitors for compliance.	June 30, 2019	

Recommendation	Open (VA's Expected Closure Date)	Closed (Closure Date)
12. The Facility Director ensures that all deficiencies identified on the Annual Physical Security Survey are addressed or corrected and monitors compliance.	June 30, 2019	
13. The Facility Director ensures that electronic access for performing or monitoring controlled substance balance adjustments is limited to appropriate staff and monitors compliance.	June 30, 2019	
14. The Facility Director ensures that the duties of the Controlled Substance Coordinator and Alternate Controlled Substance Coordinator are included in the employees' position description or functional statement.		January 28, 2019
15. The Facility Director ensures that a reconciliation of controlled substance return to pharmacy stock is performed during controlled substance inspections and monitors compliance.	June 30, 2019	
16. The Chief of Staff ensures that the geriatric evaluation performance improvement activities are reviewed by the appropriate leadership board and monitors compliance.	June 30, 2019	
17. The Associate Director for Patient Care Services ensures that all registered nurses involved in the insertion and/or management of central lines receive the required central line-associated bloodstream infection and infection prevention education and monitors compliance.	March 31, 2019	
18. The Facility Director ensures the Chief of Health Information Management facilitate the timely scanning of clinical reports into the electronic health record and monitors compliance.	June 30, 2019	

Source: OIG quarterly follow-up database. Information is current as of June 19, 2019.

APPENDIX B: JUNE 2019 FOLLOW-UP TO *CRITICAL DEFICIENCIES AT THE WASHINGTON DC VA MEDICAL CENTER*

The OIG conducted an inspection from June 3–6, 2019, to check on the implementation status of five recommendations associated with deficient conditions selected for their impact on patient care and complexity of tasks. The visit was conducted to assess whether processes were in place for sustainable improvement:

1. Patient safety and incident reporting (Recommendation 5)
2. Reprocessing of loaner surgical instruments and trays (Recommendation 12)
3. Sterile Processing Service (SPS) staff competencies (Recommendation 15)
4. General staffing plans (Recommendation 19)
5. Logistics and SPS staffing (Recommendation 20)

Because critical vacancies existed in key leadership positions in 2017–2018 that impacted the leadership team's ability to implement the facility's plans and priorities, this review also examined whether those positions had been filled permanently as of the June 2019 visit.[16]

The OIG team reviewed Veterans Health Administration (VHA) handbooks and directives, facility policies, committee meeting minutes, quality management documents, and SPS competency data. The team evaluated leadership survey data, facility staffing, and other human resource (HR)-related activities. The team also reviewed the facility's overall ranking related to the Strategic Analytics for Improvement and Learning (SAIL) measures. The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

SUMMARY OF OIG FINDINGS

In the areas reviewed, the OIG team found that conditions had largely improved since publication of the *Critical Deficiencies* report. The Executive Leadership Team (ELT) was beginning foundational work on culture change and "psychological safety" for employees.[17] In March 2019, the five ELT members participated in a National Center for Organizational Development (NCOD) survey evaluating the

[16] VA Office of Inspector General, *Interim Summary Report*, Report No. 17-02644-202, April 12, 2017. Recommendation 8 required the Under Secretary for Health to expedite the hiring of permanent positions to include the Associate Director, Nurse Executive (Associate Director for Patient Care Services), Chief of Logistics, Assistant Chief of Logistics, and supply technicians.

[17] The ELT consists of the Facility Director, Associate Director, Chief of Staff, Associate Director for Patient Care Services, and the Assistant Director. The work on psychological safety refers to the degree to which employees trust that asking questions, sharing new ideas, raising concerns, disclosing honest mistakes, and reporting violations will not be penalized or perceived negatively in the workplace.

group's strengths and challenges in three specific areas: Vision, Alignment, and Execution. Results showed that, collectively, the group had a natural inclination to be optimistic and encouraging. The results also showed that the group had a natural affinity for initiating action, which is important because people who tend to be initiating often help create a culture where being proactive is valued above maintaining the status quo. VHA NCOD also deployed a Leadership Impact Assessment and received 34 managers' and key stakeholders' responses. Scores ranged from 1 (low) to 5 (high). The top two scoring items were "[t]he ELT speaks about our vision in inspiring ways" (score 4.15) and "[t]he ELT makes it safe to speak about concerns" (score 4.09).[18]

Leaders and managers were also building infrastructure to include improved staffing, enhancing policies and procedures, and implementing monitoring and oversight processes. Sections below discuss the sequence of select findings and the remediation status at different points in 2018–2019 to assess the status of the five selected recommendations, including

- March 2018 *Critical Deficiencies* finding(s) and associated recommendation(s),
- December 2018–March 2019 VHA status updates, and
- June 2019 OIG inspection findings.

Patient Safety and Incident Reporting—Recommendation 5

The March 2018 *Critical Deficiencies* report indicated that the patient safety manager was not consistently scoring the Safety Assessment Code (SAC) for patient safety events, or entering the information into the National Center for Patient Safety (NCPS) database, in accordance with VHA policy, resulting in missed opportunities to improve patient safety.[19] Recommendation 5 required routine audits of incident reporting system entries to ascertain that all patient safety events were entered in the NCPS database as required by VHA policy. (By October 1, 2017, VHA fully transitioned to the Joint Patient Safety Reporting [JPSR] system, a system shared by VHA and Department of Defense for reporting patient safety events.[20])

[18] The Leadership Impact Assessment was deployed to Washington DC VAMC from February 25 to March 15, 2019. Fifty-three managers and stakeholders were invited to participate, and 34 completed the survey.

[19] VHA requires facilities to evaluate every reported patient safety event and assign a SAC score using a matrix that weighs the severity of harm incurred by the patient (or reasonable "worst case" if the incident is a close call) and the anticipated probability of recurrence of the incident. This SAC is graded from 1 (lowest safety risk) to 3 (highest safety risk). All events scored as a level 3 SAC must go through a root cause analysis process as this provides the means to critically assess an adverse event by asking many "whys."

[20] The JPSR system can be accessed by Department of Defense and VHA personnel, and allows users to report a patient safety event using an electronic event submission form. The facility's patient safety manager can track and trend data using an automated event management system and enhanced reporting features.

Despite the change in reporting systems, the intent of the recommendation stayed the same—to implement a system of oversight to ensure that incidents were SAC-scored and entered into an appropriate database. VHA's status update as of December 3, 2018, reported that all 677 events were assigned a SAC score for FY 2018, reflecting a 100-percent compliance rate. The recommendation was closed January 9, 2019.

In June 2019, the OIG reviewed JPSR data from October 1, 2017, to June 4, 2019, and interviewed facility and VISN patient safety staff to ensure that improvements were being sustained. The OIG confirmed that VISN staff conducted quarterly continuing audits using a tool in the JPSR system to review events. The audits included a review of patient safety staff compliance with SAC scoring requirements for all events reported in JPSR, and inter-rater reliability reviews for SAC scoring accuracy completed by VISN peers.

Reprocessing of Loaner Surgical Instruments and Trays—Recommendation 12

Critical Deficiencies noted that as of August 2017, the electronic loaner instrument tracking system had been purchased and implemented, but for a variety of reasons, staff were not consistently using it. Instead, SPS staff were using a paper log to track loaner trays. Recommendation 12 required SPS and operating room (OR) personnel to comply with policies and procedures for the proper reprocessing of loaner instruments and trays.

VHA's March 2019 status update stated that policies and procedures for the proper reprocessing of loaner instruments and trays were developed and staff were trained on the policies. Further, VHA indicated that proper reprocessing of loaner instruments and trays was audited through the quality assurance process. Per VHA's response, audit data showed avoidable case cancellations were down from 12.4 percent in 2017 to 3.6 percent from January 1, 2018, through January 31, 2019, and just six cases were canceled because of unavailable reusable medical equipment (RME) during this time. VHA also reported that loaner trays were being tracked through an electronic loaner instrument tracking system and reports were presented and reviewed at the RME Committee meeting. The OIG closed Recommendation 12 on April 28, 2019.

During the June 2019 onsite visit, the OIG validated that SPS and OR staff were consistently using the electronic tracking system and that paper logs were no longer in use. The team also reviewed avoidable case cancellation data for January 1, 2019, to May 31, 2019, and found that no cases were canceled due to unavailable RME.

SPS Staff Competencies—Recommendation 15

Critical Deficiencies identified multiple deficiencies with SPS staff competencies that included expired or undated competencies, lack of documentation regarding required training, and competencies not consistent with manufacturer's instructions. Conditions improved over the course of the initial review, so the OIG's recommendation focused on inappropriate and outdated SPS staff competencies.

Recommendation 15 required SPS employees to have appropriate, updated competencies and a demonstrated proficiency to perform their assigned duties.

VHA's March 2019 status update reported that SPS staff were trained and competent to perform in their assigned areas and that SPS had a plan to complete training for all existing staff and new employees. This recommendation remains open.

In June 2019, the OIG conducted a review of SPS staff competency documentation. The SPS Nurse Manager, who started in that position in April 2019, created binders that contained documentation of staff competencies to perform their assigned duties. The OIG team randomly selected the binders for 14 of 34 SPS staff and contract employees and reviewed four competencies per individual for compliance with guidelines:

1. Decontamination procedures and protocols for SPS
2. Use of a particular high-level disinfectant for reprocessing RME[21]
3. Operation of the ultrasonic cleaner[22]
4. Reprocessing steps for a particular laparoscope

Competencies reviewed for RME areas, like those listed above, demonstrated the employee's ability to perform each of the duties and were appropriately signed and dated by the trainer and the employee. The OIG found that documentation of competencies in the reviewed sample met VHA requirements.[23] This recommendation remains open, however, to further monitor these complex processes, particularly with the lack of a full-time RME educator.

General Staffing Plans—Recommendation 19

Critical Deficiencies outlined the facility's inability to provide the OIG with a complete list of authorized positions because of inaccurate organizational charts. Recommendation 19 required development of a staffing plan to fill vacancies that included accurate numbers of authorized positions by service.

VHA's March 2019 status update reflected completion of the organizational charts and prioritized hiring list, but additional time (until April 30, 2019) was needed to complete the staffing analysis plan. The update also reflected that Workforce Management and Consulting (WMC) had made 146 selections and

[21] High-level disinfection is a process that kills all microbial organisms using a chemical agent (a sterilant).

[22] VHA Directive 1116(2), Sterile Processing Services (SPS), March 23, 2016 states "SPS is responsible for the daily inspection of equipment used in the service. Standard Operating Procedures and instructions for all equipment used in SPS for reprocessing functions (for example, sterilizers, washers, heat sealers) must be maintained in SPS and readily available (electronic or paper copy). The SPS equipment operator must monitor charts, printouts, and gauges ensuring that the equipment is functioning within normal limits."

[23] VHA Directive 1116(2).

onboarded 120 employees.[24] These selections reflected all hiring selections at the facility, including Logistics and SPS.

During the OIG's June 2019 visit, facility leaders informed the team that additional staff had been onboarded since the last VHA update. The team also learned that facility and VISN HR staff completed service-level organizational charts, a priority hiring list, and a staffing analysis plan.

Although hiring actions were occurring, primarily through WMC activities, the OIG team noted that other HR-related challenges could stagnate or erode progress in other areas. These challenges flow from the VHA HR Modernization and Shared Services model, initiated in October 2018 with completion due in 2020. This modernization effort consolidates transactional services (such as Employee and Labor Relations and Work-life Benefits) and realigns facility HR operations under the VISN HR Officer.[25] As with any large-scale realignment, the transition to a fully developed and implemented program can pose difficulties.

As of June 6, 2019, Recommendation 19 remains open. The facility has a history of leadership and staffing challenges, and while a permanent chief was hired in September 2018, HR staffing remained low as of June 2019.[26] Furthermore, some HR staff reportedly required additional knowledge and skills, and tension was noted within the facility's HR Service and between facility and VISN HR leaders. The OIG team concluded that these conditions, coupled with the challenges in implementing a new HR system, placed the completion of day-to-day tasks and real-time HR support at the facility level at risk.

Logistics and SPS Staffing—Recommendation 20

Logistics and SPS staffing were central to many of the concerns outlined in *Critical Deficiencies*. Recommendation 20 requires the timely completion of hiring actions until staffing deficiencies in Logistics and SPS are fully resolved. VHA's March 2019 status update reflected that Logistics and SPS hires were included in the selections and onboarding completed by WMC.

During the June 2019 visit, the OIG team found that the service had increased the number of authorized staff positions from 60 to 74. Of those 74 positions, 52 had been filled. The Deputy Chief of Logistics

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[24] WMC provides VHA-wide leadership for workforce operations and administration management functions, including strategic human capital planning, labor management and labor relations, and retention and recruitment, among other support. VA Functional Organization Manual – v4.0, Description of Organization Structure, Missions, Function, Activities, and Authorities, 2017. (Website accessed on https://www.va.gov/landing_organizations.htm). The facility's contract with WMC started on July 1, 2018, and expires September 30, 2020.

[25] The modernization strategy was to "realign reporting structures, consolidate transactional services, create strategic partnerships with local resources, and establish Centers of Excellence (CoE) to promote consistent implementation of best practices in HR management at VHA." Memorandum from Executive in Charge, Office of Under Secretary for Health, October 3, 2018.

[26] From January 2012 through July 2017, the facility had 10 HR chiefs in a combination of acting and permanent capacities.

told the OIG team that Logistics also had an additional 20 positions filled through contract. The Facility Director recognized the need to monitor Logistics staffing closely.

During the June 2019 visit, the OIG team found the service increased the number of authorized staff positions from 34 to 36. Of those 36 positions, 27 had been filled. The facility informed OIG that SPS had an additional seven positions filled through contract, with three of those contractors in the process of onboarding. The staffing continues to be monitored given the time it has taken to address the critical staffing deficiencies from 2017 (21 percent for Logistics and 40 percent for SPS) to assess sustainability. Accordingly, as of June 6, 2019, Recommendation 20 remains open.

Leadership Stability

As of June 2019, all members of the senior leadership team were permanent in those roles, and with one exception, all expressed to the OIG their intentions to stay in those positions.[27] Additional service chief positions had also been filled with permanent managers.

Table 1. Senior Leaders and Select Service Chief Positions as of June 6, 2019

Position	EOD* in Position	EOD in VA
Facility Director	October 2018	2018
Associate Director	October 2018	2018
Chief of Staff	May 2016	2005
Associate Director Patient Care Services	September 2017	2007
Assistant Director	May 2018	2005
Chief of Logistics	January 2018	2018
Associate Chief of Logistics	July 2018	2007
Deputy Chief SPS Perioperative Service[28]	August 2018	2018
SPS Nurse Manager	April 2019	2019
Chief of HR	September 2018	2003

**EOD – Enter on Duty*

Source: OIG compilation of information received from facility leaders.

[27] The Associate Director, who had been in his role since October 2018, announced his leaving in late July.

[28] The Deputy Chief SPS and Perioperative Care was a new position established by the facility. The incumbent is responsible for SPS, the OR, and Same-Day Surgery operations. This position replaced the Deputy Nurse Executive for Operations position.

JUNE 2019 FOLLOW-UP CONCLUSION

It was the OIG team's assessment that the Executive Leadership Team was cohesive in its general plans and vision for the facility. Conditions in the areas reviewed had improved since the March 2018 *Critical Deficiencies* report, and leaders and managers were taking additional steps to enhance the facility's culture and strengthen key systems. Continued vigilance is needed, however, to maintain and build on improvements.

The OIG briefed VISN and facility leaders on June 6, 2019, about the general findings of this progress check.