DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Follow-up to Clinical and Administrative Concerns at the Cincinnati VA Medical Center

Ohio

ADMINISTRATIVE SUMMARY | REPORT #17-05398-177 | MAY 23, 2018

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Administrative Summary

Why the Inspection was Initiated

Senator Sherrod Brown requested that the VA Office of Inspector General (OIG) follow up on several issues at the VA Medical Center (facility) in Cincinnati, Ohio, that had previously been cited in OIG or Veterans Health Administration's Office of the Medical Inspector (OMI) reports. Specifically, OIG was asked to evaluate the adequacy of policies and practices in several areas:

A. Separation of clean and dirty materials in storage areas

B. Reporting and follow-up of reusable medical equipment (RME) reprocessing errors

C. Identification and management of Methicillin-resistant *Staphylococcus aureus* (MRSA) healthcare-associated infections (HAI)

D. Recruitment and retention of nurses

How the Inspection was Conducted

The OIG conducted an on-site inspection at the facility October 16–17, 2017 in conjunction with an OIG Comprehensive Healthcare Inspection Program (CHIP) review. The OIG team inspected the operating room (OR) Case Cart Room, OR Orthopedic Case Cart Room, OR Inner Core, Dental Clinic, Sterile Processing Service (SPS), Specialty Clinic, Medical Intensive Care Unit (ICU), and Surgical ICU. The OIG team reviewed VHA directives, relevant facility documentation, and Strategic Analytics for Improvement and Learning (SAIL) data. The OIG interviewed the facility Director, the Acting Chief of SPS, Infection Control (IC) team members, the Chief Nurse Executive, and a Human Resource Management Service (HRMS) specialist.

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 Findings

A. Separation of Clean and Dirty Materials in Storage Areas

Senator Brown's staff expressed concern about the facility's previous practice of storing clean and dirty materials in the same location. This condition was reported in OIG Healthcare Inspection Report No. 16-02094-219, dated May 3, 2017.[1]

The Joint Commission's "*Comprehensive Accreditation and Certification Manual,*" Hospital Accreditation Requirements, IC.02.02.01, EP 4 states the following: "The organization implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies."

At the time of OIG's site visit in October 2017, the facility had adequately addressed this issue:

- Clean and dirty materials were stored separately in the eight areas inspected.
- Storage areas were generally clean.
- Storage areas were uncluttered and had adequate lighting.
- Sterile supplies were intact.
- Commercial supplies were in-date (not expired).
- There was a method or device to monitor temperature and humidity.

B. Reporting and Follow-up of RME Reprocessing Errors

Senator Brown's staff expressed concern about RME and SPS following an OMI report.[2] Veterans Health Administration (VHA) Directive 1116(2), *Sterile Processing Services (SPS),* March 23, 2016,[3] requires, among other items, (1) a quality assurance program for RME reprocessing, and (2) annual facility-led inspections of SPS. VHA's National Program Office for Sterile Processing fiscal year (FY) 2017 SPS Clinical Area Inspection Tool template includes the question "Does the facility track adverse events related to sterilizing RME?"

At the time of OIG's site visit in October 2017, the facility had adequately addressed this issue. OIG inspectors found that the facility did not have a written policy or procedure for reporting RME reprocessing errors; however, the facility had an effective process in place. Dental Service and Surgical Service used Censitrac, an electronic reporting system, for reporting and following up RME reprocessing errors. Through Censitrac, SPS documented the follow-up and generated a

[1] VAOIG, Healthcare Inspection - *Environment of Care and Other Quality Concerns*, Cincinnati VA Medical Center Cincinnati, Ohio, (Report No. 16-02094-219 May 3, 2017).

[2] Department of Veterans Affairs, Cincinnati Veterans Affairs Medical Center Cincinnati, Ohio, TRIM 2016-D-1082, May 8, 2016.

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

Non-Conforming Product Report. The reports were shared with the RME Committee, Clinical Executive Board, and Surgical Work Group.

C. Identification and Management of MRSA

Senator Brown's staff expressed concern about the facility's MRSA rates following an OMI report.[4] Prior to FY 2016, the facility's MRSA rates periodically exceeded VHA's national average.

VHA Directive 2010-006, *Methicillin-resistant Staphylococcus aureus (MRSA) Prevention Initiative*, February 3, 2010[5] requires the implementation of a standardized initiative to reduce transmission and subsequent infections in veterans.

The OIG found a decreasing number of new MRSA infections in comparison to previous years. While the facility's rolling 12-month MRSA infection rate in FY 2017 exceeded VHA averages, the facility did not report any new MRSA infections in quarters (Qs) 3-4 FY 2017. Facility leaders reported that in addition to following VHA Directives for IC, they have also

- Increased IC staffing,
- Extended IC staff hours to improve visibility and availability, and
- Provided "on-the-spot" training when observed practices are deficient.

As of January 31, 2018, the facility was taking reasonable actions to prevent new MRSA infections. Ongoing vigilance is required to sustain improvements.

D. Recruitment and Retention of Nurses

Senator Brown's staff expressed concern about the adequacy of nurse staffing at the facility.

VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010[6] requires facilities to use a nurse staffing methodology to plan staffing levels appropriate at each facility to "ensure that a qualified and competent nursing workforce is available to provide safe, quality health care."

The SAIL measure of registered nurse (RN) turnover rate includes losses of RNs due to termination and quit (voluntary separation).[7] As of the end of Q4 FY 2017, the facility's overall

[4] MRSA HAI rates are defined as the number of MRSA HAIs reported per 1,000 bed days of care.

[5] This VHA Directive expired February 28, 2015; however, the OIG considers previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

[6] This VHA Directive was in effect at the time of the events discussed in this report; it was rescinded and replaced by VHA Directive 1351, *Staffing Methodology for VHA Nursing Personnel*, December 20, 2017.

[7] SAIL data are from VHA; OIG did not independently verify this information.

RN turnover rate per SAIL was lower than average. However, this SAIL measure does not identify nurse staffing shortages in specific clinical areas. The Chief Nurse Executive reported the following as of January 25, 2018.

- There were 8 RN vacancies (of 28 full time equivalent [FTE] employee positions) in the Medical ICU and 4 RN vacancies (of 28 FTE) in the Surgical ICU,
- There were 11 beds in Medical ICU and 10 beds in Surgical ICU but the facility was not operating at its full capacity (accepted a maximum of 8 patients) in both ICUs due to staffing issues,
- The facility was on diversion twice since December 2017 due to ICU capacity, and
- Nurse recruitment and retention efforts continue to be difficult due to pay parity challenges.

As of early February 2018, the Facility Director and HRMS specialist reported improvement efforts:

- The facility was in the process of implementing a new pay schedule for critical care nurses; pay increases tentatively scheduled for March 2018.
- Leadership will revisit additional pay increases in the next FY.
- The facility has requested a consultation visit from an external VA team to assist with identifying additional ways of recruiting and retaining qualified ICU nurses.

The OIG determined that facility leadership's improvement efforts appear appropriate in the context of ongoing challenges with recruitment and retention of ICU nurses. Ongoing vigilance is required to improve and maintain ICU nurse staffing.

Conclusion

The OIG found storage areas that were inspected to be generally clean, with clean and dirty materials stored separately. Although the facility did not have a written policy or procedure for reporting RME reprocessing errors, an appropriate process, including an electronic tracking system, was in place. At the time of the site visit in October 2017, the facility had adequately addressed these issues.

The facility's MRSA surveillance and prevention activities appeared to be improving, as the facility did not report any new infections in Qs 3 and 4, FY 2017. At the time of OIG's follow-up in late January 2018, the facility was taking reasonable actions to prevent new MRSA infections.

The facility has reportedly had difficulty recruiting and retaining ICU nurses because it is unable to meet salaries offered by other healthcare organizations. At the time of OIG's final follow-up in early February 2018, the facility was taking reasonable steps to ensure patient care and safety when ICU nurse staffing was not optimal, and to improve nurse recruitment and retention through pay parity efforts.

The OIG made no recommendations.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the report. (See Appendixes A and B, pages 6–7 for the Directors' comments.) No further action is required.

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

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 26, 2018.

From: Network Director, VISN 10 (10N10))

Subj: Healthcare Inspection—Follow-up to Clinical and Administrative Concerns, Cincinnati VA Medical Center, Ohio

To: Director, Rapid Response, Office of Healthcare Inspections (54RR)

I reviewed the Administrative Summary and concur with the Cincinnati VA Medical Center Director's response.

(Original signed by:)

Jane J. Johnson
Acting VISN Director
For Robert P McDivitt, FACHE

Appendix B: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: April 18, 2018

From: Director, Cincinnati VA Medical Center (539/00)

Subj: Healthcare Inspection—Follow-up to Clinical and Administrative Concerns, Cincinnati VA Medical Center, Ohio

To: Director, VA Healthcare System (10N10)

I concur with the findings of the Office of Inspector General's report, Follow-up to Clinical and Administrative Concerns, Cincinnati VA Medical Center.

(Original signed by:)

Vivian T. Hutson, FACHE

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Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Larry Selzler, MSPT Victoria Coates, LICSW, MBA Lindsay Gold, LCSW Eileen Keenan, MSN, RN Monika Spinks, BSN, RN
Other Contributors	Toni Woodard, BS

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