US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Review of Ear, Nose, and Throat Surgery-Related Sterile Processing Services Concerns at the Michael E. DeBakey VA Medical Center in Houston, Texas

Healthcare Inspection | **25-02152-136** | **June 16, 2026**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Michael E. DeBakey VA Medical Center (facility) in Houston, Texas, to evaluate concerns regarding Sterile Processing Services (SPS) deficiencies and their impact on ear, nose, and throat surgeries. The inspection was initiated on March 31, 2025, following a complaint alleging that SPS leaders did not effectively manage reusable medical device (RMD) inventory, which resulted in broken and missing instruments and subsequent cancellations of ear, nose, and throat procedures. The OIG conducted an on-site visit from June 10 through 12, 2025, analyzed relevant policies, surgical data, and patient safety reports, and reviewed facility documentation through January 29, 2026.

Inventory Tracking Processes

Veterans Health Administration (VHA) Directive 1116(2), *Management of Critical and Semi-Critical Reusable Medical Devices*, requires SPS lines to use a specific electronic tracking and data management system to track and record all RMD processing activity.[1] The OIG learned that facility SPS staff used the CensiTrac electronic tracking and data management system. However, the OIG identified inconsistencies in SPS processes and observed that SPS staff did not use all available CensiTrac capabilities to help track and manage the scanning, inspection, and assembly of instruments. This likely resulted in inventory inaccuracies.

The OIG found instruments were not consistently etched (marked) for identification or scanned into CensiTrac. In addition, SPS staff reported sending incomplete instrument sets to the operating room with count sheets documenting the missing instruments. Operative care line staff reported the count sheets used to verify tray contents were inaccurate at times and documented instruments as present when they were missing.

Leadership of Sterile Processing Services Operations

VHA Directive 1116(2) requires facilities to have a dedicated chief and assistant chief of SPS.[2] The chief of SPS position remained without a permanent leader for almost three years. The assistant chief of SPS role, which had been vacant since October 2023, remained unfilled as of late April 2026.

Additionally, the associate director of patient care services position, responsible for SPS quality and process improvement, was held by three acting individuals from August 2024 to August 2025, when it was permanently filled.

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[1] VHA Directive 1116(2), *Management of Critical and Semi-Critical Reusable Medical Devices*, July 17, 2023, amended September 9, 2024.

[2] VHA Directive 1116(2).

Continued leadership vacancies and turnover, combined with the lack of a full-time dedicated SPS chief, may have prevented effective oversight of SPS inventory management.

Ear, Nose, and Throat Surgical Cancellations Related to Sterile Processing Services

The OIG reviewed the electronic health records of 10 patients and found ear, nose, and throat surgery cancellations were often due to broken, missing, or contaminated RMDs. Two patients received anesthesia or other medications in preparation for surgeries that were ultimately canceled. The OIG is concerned that mismanagement of instruments reduces surgery efficiency and wastes taxpayer dollars.

Per VHA's *10N Guide to VHA Issue Briefs*, when a case is canceled due to SPS equipment issues, SPS staff at the facility are required to create an issue brief.[3] The OIG determined that SPS staff did not initiate issue briefs for all surgery cancellations resulting from RMD issues, and the results of action plans outlined in completed briefs were not presented to the RMD Committee for review.

The OIG made three recommendations to the Facility Director on hiring an assistant chief of SPS, reviewing RMD inventory management and oversight processes, and tracking issue briefs related to surgery cancellations from initiation to closure.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

[3] VA Deputy Secretary for Health for Operations and Management (10N), *10N Guide to VHA Issue Briefs*, updated March 29, 2018.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the OIG recommendations. The Facility Director reported that recruitment for an SPS assistant chief was underway and SPS RMD inventory management and oversight processes are reviewed for compliance and deficiencies, and described the process to track issue briefs related to surgery cancellations (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

David C. Krulak, MD, MPH, MBA
Assistant Inspector General
for Healthcare Inspections

Contents

Abbreviations

OIG	Office of Inspector General
RMD	reusable medical device
SPS	Sterile Processing Services
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) initiated a healthcare inspection on March 31, 2025, at the Michael E. DeBakey VA Medical Center (facility) in Houston, Texas, to evaluate allegations of Sterile Processing Services (SPS) deficiencies leading to cancellations of ear, nose, and throat surgeries, and assess leaders' responses to the allegations. The OIG conducted a site visit from June 10 through 12, 2025, and reviewed facility documentation through January 29, 2026.

Background

The facility, part of Veterans Integrated Service Network (VISN) 16, consists of a medical center in Houston, Texas, and 12 community-based outpatient clinics.[1] The facility is classified as level 1a (high complexity) and provides a range of healthcare services including medicine, surgery, mental health, and primary care.[2]

Sterile Processing Services

SPS is a distinct service line responsible for reprocessing reusable medical devices (RMDs) under Veterans Health Administration (VHA) Directive 1116(2), *Management of Critical and Semi-Critical Reusable Medical Devices*.[3] RMDs are instruments or devices, such as surgical forceps and clamps, "that can be reprocessed and reused on multiple patients."[4] Reprocessing describes the steps involved in making a contaminated item reusable, including cleaning, decontamination, and disinfection or sterilization.[5] The Joint Commission identifies that proper reprocessing of RMDs "is essential to prevent and control infection among patients" and limit patient and staff exposure to chemicals.[6]

Once RMDs are sent to SPS, they are reprocessed according to manufacturer specifications and stored for future use or immediately prepared for another procedure. During reprocessing, SPS

[1] The 12 community-based outpatient clinics are located in Beaumont, Conroe, Galveston, Houston, Humble, Katy, Lake Jackson, Lufkin, Richmond, Sugar Land, Texas City, and Tomball, Texas.

[2] VHA Office of Productivity, Efficiency and Staffing (OPES), "VHA Facility Complexity Model Fact Sheet." The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and operational cost. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and level 3 facilities are the least complex.

[3] VHA Directive 1116(2), *Management of Critical and Semi-Critical Reusable Medical Devices*, July 17, 2023, amended September 9, 2024.

[4] VHA Directive 1116(2).

[5] VHA Directive 1116(2).

[6] The Joint Commission, *The Joint Commission Guide to Reprocessing Reusable Medical Devices*, 2023.

staff should inspect and remove damaged RMDs—such as chipped or bent instruments—from service. Damaged instruments can increase the risk of infection and compromise a procedure.

Instrument Tracking

The American National Standards Institute and the Association for the Advancement of Medical Instrumentation standards require healthcare facilities to etch, bar code, or color code individual instruments for tracking.[7] Instrument etching is a way of marking surgical instruments and helping ensure staff can identify instrumentation after sterile processing.[8] These standards also require instrument count sheets (tools used to facilitate instrument inventory) for surgical instrument sets to verify contents.[9]

CensiTrac is an electronic management system that tracks surgical instruments from the beginning of reprocessing through transporting, storage, and use.[10] CensiTrac records scanned instruments, guides tray assembly and tracking, and manages inventory. RMD inventory management is important because it helps staff ensure they have enough clean, functional instruments to provide care.

Allegations and Related Concerns

The OIG received a complaint in early March 2025 alleging that SPS staff did not effectively manage RMD inventory and distributed broken instruments and sets with missing items, resulting in cancellation of ear, nose, and throat surgeries. On March 31, 2025, the OIG initiated a hotline inspection to evaluate SPS practices for ear, nose, and throat RMDs and review facility leaders' response to the SPS allegations.

Scope and Methodology

The OIG conducted an on-site visit from June 10 through 12, 2025. Virtual interviews were conducted prior to, during, and after the site visit through July 30, 2025. The OIG interviewed selected current and former facility leaders, providers, and staff who had relevant knowledge of ear, nose, and throat surgery and Sterile Processing Services (SPS).

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[7] ANSI/AAMI ST90:2017, *Processing of Health Care Products—Quality Management Systems for Processing in Health Care Facilities, 7.5.3.1*, 2017.

[8] Kyros Ipaktchi et al., "Current Surgical Instrument Labeling Techniques May Increase the Risk of Unintentionally Retained Foreign Objects: A Hypothesis," *Patient Safety in Surgery* 7, no. 31 (2013), 1–4, https://doi.org/10.1186/1754-9493-7-31.

[9] "Frequently Asked Questions," AORN eGuidelines+, accessed July 31, 2025, https://aornguidelines.org/faq/content?gbosid=403535.

[10] "CensiTrac InstrumenTrac," VA, https://www.oit.va.gov/Services/TRM/ToolPage.aspx?tid=8145, accessed January 6, 2026.

Members of the OIG team observed key functional areas related to SPS on June 10 and 12, 2025, including the preparation and assembly, scope reprocessing, and sterilization areas.

The OIG reviewed applicable VHA directives, facility policies related to SPS and patient safety, facility committee meeting minutes, quality and management review documents, and other relevant materials. Additionally, the OIG reviewed ear, nose, and throat surgical cancellations and delays related to SPS, as well as Joint Patient Safety Reports—reports made through a web-based system to capture patient safety events from October 1, 2023, through May 31, 2025.[11]

In the absence of current VA or VHA policy, the OIG considered 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).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

The inspection team's analyses relied on inspectors identifying significant information from evidence based on professional judgment, as supported by the Council of Inspectors General on Integrity and Efficiency's standards.[12] During the preparation of this report, the inspection team used peer-reviewed standardized, structured, and evaluated prompts in Copilot Chat (Microsoft) to review inspection data such as interview transcripts, documents, questionnaire responses, and physical observations. After using this tool, the team confirmed fidelity of the generated output to the source material, edited the report, and take full responsibility for the content of the publication. All references are for original source material, not artificial intelligence (AI)-generated content. The Office of Healthcare Inspections inspection teams do not use AI as the principal basis for decision-making or actions; therefore, the usage does not meet the definition of high-impact as laid out by Section 4(a) of the Office of Management and Budget (OMB)

[11] VHA Directive 1050.01(1), *VHA Quality and Patient Safety Programs*, March 24, 2023, amended March 5, 2024.

[12] Council of the Inspectors General on Integrity and Efficiency, *Quality Standards for Inspection and Evaluation*, December 2020.

Memorandum M-25-21, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust."[13]

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.

Inspection Results

1. Inventory Tracking Processes

The OIG substantiated that Sterile Processing Services (SPS) practices for reusable medical devices (RMDs) did not meet VHA requirements.

VHA Directive 1116(2), *Management of Critical and Semi-Critical Reusable Medical Devices,* requires SPS lines to use a specific electronic tracking and data management system to track and record all RMD processing activity.[14]

The OIG found gaps in SPS processes related to scanning, inspecting, assembling, and reordering instruments. In addition, SPS staff inconsistently used CensiTrac to track instruments, which likely resulted in inventory inaccuracies. An overview of the facility's SPS process steps is summarized in table 1 and described in more detail below.

Table 1. Sterile Processing Services Preparation Area Process Steps and Identified Issues

Process Step	Description	OIG Identified Issue
Scan Instruments	Scan individual etched instruments into CensiTrac for item-level tracking or manually select item in CensiTrac by visual inspection.	Some instruments not etched.
Inspect Instruments	Visually inspect each instrument. Discard any broken or rusted instruments into the designated red bin.	Discarded instruments not consistently tracked.

[13] Director for the Office of Management and Budget, "Accelerating Federal Use of AI through Innovation, Governance, and Public Trust," memorandum to Heads of Executive Departments and Agencies, April 3, 2025.
[14] VHA Directive 1116(2).

Process Step	Description	OIG Identified Issue
Assemble Trays	Use approved count sheets in CensiTrac to verify and assemble trays with the correct instruments.	Incomplete trays sent to the operating room and count sheets often inaccurate relative to instruments in the tray.
Order Replacements	Order replacement instruments for any incomplete surgical sets due to discarded or missing items.	Inconsistent tracking of items needing to be ordered.

Source: OIG interviews with staff.

According to SPS staff, instruments that are not etched can be visually identified and manually selected in CensiTrac, but inexperienced staff may have difficulty identifying unetched items by sight. This can delay tray assembly and affect accuracy, and may cause inconsistencies in CensiTrac inventory. The SPS chief and SPS staff confirmed that not all instruments are etched for identification, which limits CensiTrac scanning capabilities. The SPS chief expressed unawareness of how many instruments still needed etching, discussed working with an outside contractor to etch instrument sets, and acknowledged there is no planned timeline for completion.

The OIG learned through interviews that SPS staff are responsible for visually inspecting instruments as well as discarding broken or contaminated instruments into one of two red bins. (See figure 1.) The technician notifies the operating room liaison either verbally or through email about the discarded instrument. The operating room liaison is responsible for tracking discarded instruments and ordering replacements. However, the liaison reported SPS technicians do not consistently communicate which instruments need replacement. The SPS chief identified tracking of discarded instruments and replacement orders as a gap in SPS inventory management processes.

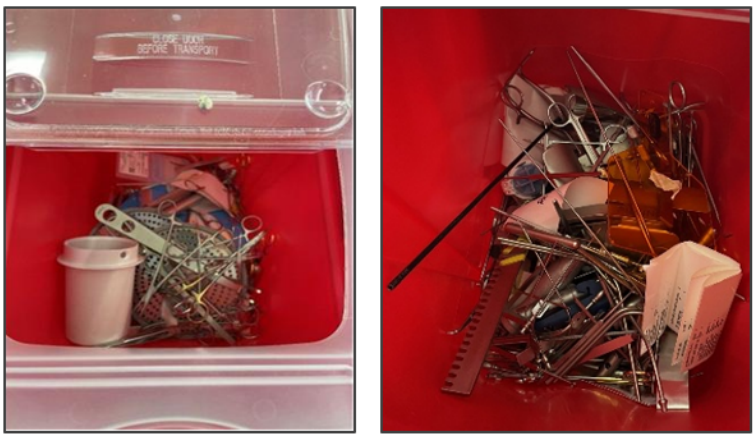

Figure 1. *Discarded instruments in two red bins in the preparation and assembly area of SPS.*
Source: VA OIG; Houston, TX; June 12, 2025.

According to SPS staff, once a tray has been assembled, a count sheet, a printout from CensiTrac that provides the baseline instrument count for each surgical tray, is attached to the outside of the tray. A tray is considered complete when all instruments are physically present. Operative care line staff informed the OIG that count sheets are sometimes inaccurate and identify instruments as present when they are missing, which can delay the surgery or result in cancellation.

During interviews, SPS staff reported sending incomplete surgical trays to the operating room that had count sheets documenting missing instruments. The SPS chief acknowledged this practice does not meet expectations and reported a plan to support staff in completing surgical trays. The OIG reviewed a CensiTrac inventory report sample, which documented a large number of incomplete ear, nose, and throat sets. The SPS chief acknowledged awareness of the missing instruments and challenges with not having visibility into the status of instruments ordered.

The OIG determined SPS did not consistently provide needed ear, nose, and throat instruments for planned surgical procedures, causing delays or cancellations potentially affecting patient care. The OIG determined that SPS leaders did not ensure appropriate tracking and management of RMD for ear, nose, and throat surgeries.

2. Leadership of Sterile Processing Services Operations

The OIG determined that the lack of consistent leadership contributed to an inability to manage SPS operations, including inventory management.

VHA Directive 1116(2) requires facilities to have a dedicated chief with no collateral duties and an assistant chief of SPS.[15]

[15] VHA Directive 1116(2).

However, the facility remained without a permanent SPS chief for almost three years from May 9, 2022, to April 6, 2025. In August 2024, the SPS business manager for the clinical practice office assumed the role of the acting SPS chief. In an interview with the OIG, the prior acting SPS chief admitted to maintaining SPS business manager duties while serving in the SPS chief position. A permanent SPS chief was hired in April 2025.

According to VHA's assistant chief of SPS functional statement, the position "assesses, plans, implements, and evaluates outcomes in the SPS program"; is responsible for the coordination of SPS across the continuum of care; and "impact[s] the entire SPS department."[16] The assistant chief of SPS role, which had been vacant since October 2023, remained unfilled as of late April 2026. A facility leader described multiple challenges in hiring for the position and the Facility Director updated the OIG that the position was scheduled to be posted.

The associate director of patient care services is the executive leader responsible for overseeing all SPS quality and process improvement, leadership, and staff recruitment and retention efforts.[17] The position was held by three different acting leaders from August 2024 to August 2025, when it was permanently filled.

Continued leadership vacancies and turnover, combined with the lack of a full-time, dedicated SPS chief, may have prevented effective oversight of SPS inventory management.

3. Ear, Nose, and Throat Surgical Cancellations Related to Sterile Processing Services

The OIG substantiated that ear, nose, and throat surgeries were delayed or canceled due to broken, contaminated, or missing surgical instruments. However, the OIG did not identify patient harm caused by these delays or cancellations. The OIG is concerned that mismanagement of instruments reduces surgery efficiency and wastes taxpayer dollars.

VHA Directive 1116(2) requires SPS to ensure appropriate management of RMDs in the facility.[18] VA's *Sterile Processing Service and Logistics Service Design Guide* advises SPS service lines that "instrument sets, patient care equipment, and other medical devices must be

[16] "Veteran Health Administration Registered Nurse VN-0610-Nurse 1 Level 1 Assistant Chief – Sterile Processing Service," VA Office of Nursing Services, accessed October 10, 2025, https://dvagov.sharepoint.com/:w:/r/sites/VHANursingQuals/_layouts/15/Doc.aspx?sourcedoc=%7B59D5D6A5-6E1C-44EF-AFCB-3EC133980143%7D&file=Functional%20Statement%20Nurse%20I%20Level%201%20Sterile%20Processing%20Service%20(SPS)%20Assistant%20Chief.docx&wdLOR=cC61F28C6-2554-45BB-9167-B178AB21CD5F&action=default&mobileredirect=true. (This site is not publicly accessible.)

[17] VHA Directive 1116(2).

[18] VHA Directive 1116(2).

processed and distributed in an accurate and timely manner so that veterans care is not adversely affected."[19]

During interviews with the OIG, one operative care line service leader acknowledged awareness of ear, nose, and throat surgeons receiving either contaminated surgical instruments or surgical tray sets with missing instruments from SPS. Two ear, nose, and throat surgeons referred to occasions when instruments were not available for procedures, which led to cancellations and rescheduling of surgeries, and the Chief of Staff reported concerns with instruments causing surgical cancellations and delays.

To further understand the impact on patient care, the OIG requested surgical data showing ear, nose, and throat cancellations and delays related to SPS, as well as Joint Patient Safety Reports between October 1, 2023, and May 6, 2025.

The OIG completed an electronic health record review for 10 of the 11 patients associated with the concerns of instruments not being available that led to cancellations and rescheduling or delays.[20] The OIG identified that of seven ear, nose, and throat surgeries canceled, five were SPS-related and involved broken, missing, or contaminated RMDs. Of the five patients with SPS-related surgery cancellations, two were administered medications before the instrument issue was discovered. While all patients were likely inconvenienced by the cancellations, the OIG did not identify patient harm.[21]

4. Ear, Nose, and Throat-Related Issue Briefs

The OIG determined that one issue brief was not completed as required for ear, nose, and throat cancellations that resulted from an SPS-related issue.

When a surgical case is canceled due to SPS equipment issues, SPS staff are required by VHA's *10N Guide to VHA Issue Briefs* to create an issue brief, a document providing leaders within the organization with information regarding situations that affect care.[22]

During interviews, the Acting Facility Director discussed being made aware of surgery cancellations caused by RMD issues through Joint Patient Safety Reports, the daily hospital activity report, and issue briefs. SPS leaders reported being made aware of the cancellations through the SPS operating room liaison or patient safety reports.

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[19] VA Office of Construction & Facilities Management, *Sterile Processing Service and Logistics Service Design Guide*, revised September 1, 2022.

[20] The OIG did not have access to patient identifiers, and therefore, was unable to complete an electronic health record review for one delayed case. However, the OIG believes it unlikely the 13-minute delay caused patient harm.

[21] Additionally, the OIG identified four delays in ear, nose, and throat surgeries related to sets not being prepared timely or missing critical RMDs without patient medical impact.

[22] VA Deputy Secretary for Health for Operations and Management(10N), *10N Guide to VHA Issue Briefs*, updated March 29, 2018.

The OIG reviewed surgical data; operative care line tracking of ear, nose, and throat surgery cancellations; the daily hospital activity report for the corresponding dates of cancellations; Joint Patient Safety Reports related to ear, nose, and throat procedure cancellations; and issue briefs regarding ear, nose, and throat SPS concerns for events between October 1, 2023, and May 31, 2025. From this document review, the OIG identified five ear, nose, and throat procedure cancellations attributed to broken, missing, or contaminated RMDs. One of these cancellations occurred in June 2024, during the period when the SPS chief position was vacant, and did not have a corresponding issue brief.

The OIG identified that the prior acting SPS chief completed three issue briefs addressing four cancellations, with action plans indicating the results would be presented to the RMD Committee—a multi-disciplinary quality oversight body for RMDs that is responsible for reviewing open RMD action plans.[23] The OIG reviewed RMD Committee meeting minutes and found no evidence of action plan resolution for any of the issue briefs. The OIG also reviewed Clinical Executive Board meeting minutes and found the prior acting SPS chief and the current SPS chief provided quarterly presentations on VISN SPS audit findings, corrective actions, and status. However, the OIG did not find evidence of issue brief action plan discussions.

The OIG determined that SPS did not initiate an issue brief for one surgery cancellation that resulted from RMD issues or ensure action plans identified in issue briefs were completed. Additionally, the OIG identified results of the issue brief action plans were not presented to the RMD Committee, which limits the committee's ability to review the effectiveness of those plans.[24] Together these gaps affect facility leaders' ability to prevent recurring RMD issues that lead to surgery cancellations.

Conclusion

The OIG substantiated that the SPS service line did not ensure appropriate tracking and management of RMDs. After reviewing data showing ear, nose, and throat procedure cancellations and delays associated with SPS, the OIG identified five surgery cancellations related to broken, missing, or contaminated RMDs.

Although facility leaders were aware of procedure cancellations and delays resulting from inadequate instrumentation, the OIG could not verify they acted to resolve the issues, which could affect their ability to prevent recurrence. The OIG also identified a pattern of SPS and facility leadership positions that were not permanently filled. A new permanent SPS chief was hired in April 2025 after the position had remained vacant or was filled with staff in an acting

[23] VHA Directive 1116(2).

[24] VHA Directive 1116(2).

capacity for almost three years. As of April 2026, the assistant SPS chief position remained vacant.

The OIG concluded that the lack of consistent leadership contributed to SPS operational gaps and accompanying risk of patient harm. The OIG is concerned that mismanagement of surgical instruments reduces efficiency and wastes taxpayer dollars.

In response to the three OIG recommendations, the Facility Director reported ongoing recruitment of an SPS assistant chief and review of SPS RMD inventory management and oversight processes, and described the process to track issue briefs related to surgery cancellations.

The OIG is aware of VA's transformation in VHA's management structure. The OIG will monitor implementation and focus its oversight efforts on the effectiveness and efficiencies of programs and services that improve the health and welfare of veterans and their families.

Recommendations 1–3

1. The Michael E. DeBakey VA Medical Center Director uses available resources to help recruit and hire an assistant chief of Sterile Processing Services.

2. The Michael E. DeBakey VA Medical Center Director, in conjunction with the chief of Sterile Processing Services, reviews reusable medical device inventory management and oversight processes to ensure compliance with Veterans Health Administration requirements, identifies deficiencies, and takes action as warranted.

3. The Michael E. DeBakey VA Medical Center Director reviews processes to track issue briefs related to surgery cancellations resulting from reusable medical device issues from initiation to closure, identifies deficiencies, and takes action as necessary.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 8, 2026

From: Director, South Central Veterans Affairs (VA) Health Care Network (10N16)

Subj: VA Office of Inspector General (OIG) Report, Review of Ear, Nose, and Throat Surgery-Related Sterile Processing Services Concerns at the Michael E. DeBakey VA Medical Center in Houston, Texas

To: Director, Office of Healthcare Inspections (54HL00)
Chief Integrity and Compliance Officer (10OIC)

1. Thank you for the opportunity to review the draft report. I reviewed the action plan provided by the facility and concur with the response.

2. Should you need further information, contact the Veterans Integrated Services Network Quality Management Officer.

(*Original signed by:*)

Fernando O. Rivera, FACHE

[OIG comment: The OIG received the above memorandum from VHA on May 12, 2026.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 11, 2026

From: Director, Michael E. DeBakey VA Medical Center (580)

Subj: Healthcare Inspection—Review of Ear, Nose, and Throat Surgery-Related Sterile Processing Services Concerns at the Michael E. DeBakey VA Medical Center in Houston, Texas

To: Director, South Central VA Health Care Network (10N16)

1. We appreciate the opportunity to review and comment on the OIG report Review of Ear, Nose, and Throat Surgery-Related Sterile Processing Services Concerns at the Michael E. DeBakey VA Medical Center in Houston, Texas.

2. I have reviewed and concur with the report and recommendations. I have also reviewed the documentation and concur with the response as submitted.

3. We appreciate the opportunity for this review in our continuous improvement efforts for our Veterans and in furtherance of our high reliability journey.

4. Should you need further information, please contact the Chief of Quality Management & Patient Safety.

(*Original signed by*:)

Amir Farooqi, FACHE
Executive Director, MEDVAMC

[OIG comment: The OIG received the above memorandum from VHA on May 12, 2026.]

Facility Director Response

Recommendation 1

The Michael E. DeBakey VA Medical Center Director uses available resources to help recruit and hire an assistant chief of Sterile Processing Services.

_X _Concur

____Nonconcur

Target date for completion: September 2026

Director Comments

The position of assistant chief of Sterile Processing Services (SPS) was made inactive by the facility during the period of strategic hiring. The facility has received approval to move forward with hiring, and the position was scheduled posted for recruitment on April 23, 2026. This recommendation will be considered complete upon the assistant chief of Sterile Processing Services being hired and onboarded.

Recommendation 2

The Michael E. DeBakey VA Medical Center Director, in conjunction with the chief of Sterile Processing Services, reviews reusable medical device inventory management and oversight processes to ensure compliance with Veterans Health Administration requirements, identifies deficiencies, and takes action as warranted.

_X _Concur

____Nonconcur

Target date for completion: December 2026

Director Comments

The SPS Chief is actively involved with reusable medical device inventory management and oversight processes. The Chief is an active member of the Clinical Product Review Committee where facility equipment and reusable medical devices are discussed and reviewed monthly. Reusable medical device (RMD) inventory levels are tracked and reported through recurring CensiTrac reports. The SPS department is currently working to utilize CensiTrac to its full capability by having all instrumentation laser etched for count sheet and scanning accuracy and set completeness. A monthly report is generated for compliance, and monitoring will continue until the department sustains at least 90% compliance for six consecutive months. CensiTrac reports are used to identify deficiencies and are reported at the facility RMD Committee. RMD inventory non-conformities are also discussed and reviewed in the RMD Committee. Action is

taken when warranted and reflected in the committee minutes. The RMD Committee reports to the Nurse Executive Council, which is part of the facility governance structure.

Recommendation 3

The Michael E. DeBakey VA Medical Center Director reviews processes to track issue briefs related to surgery cancellations resulting from reusable medical device issues from initiation to closure, identifies deficiencies, and takes action as necessary.

_X _Concur

____Nonconcur

Target date for completion: April 2026 (Request Closure)

Director Comments

The Michael E. DeBakey VA Medical Center Director, in conjunction with the SPS Chief, reviewed the processes for tracking issue briefs related to RMD surgery cancellations, identified the existing governance structure as effective, and confirmed action is taken when deficiencies arise. Through communication with end-users, SPS initiates issue briefs related to RMD which are tracked from commencement to closure with mitigation strategy implementation to help prevent recurrence. During the monthly RMD committee meeting, non-conformities, surgical cancellations, and associated issue briefs are presented for review. All RMD-related issue briefs include any identified deficiencies with actions taken by the SPS department to mitigate reoccurrences, which may include procuring more instrumentation, identifying alternative instrumentation for utilization, and reeducation to enhance staff knowledge base. All issue briefs are reviewed weekly in the Pentad Operations meeting, to include surgery cancellations resulting from reusable medical device issues. Quarterly, SPS conducts retrospective reviews to identify trends and mitigate potential future issues. Our current process includes a multidisciplinary team huddle daily to ensure communication that allows for a prospective review of scheduled surgical cases.

OIG Comments

The OIG considers this recommendation open to allow time for the submission of documentation demonstrating issue brief initiation for all surgeries cancelled due to SPS issues and issue brief action plans being presented to RMD committee meetings.

OIG Contact and Staff Acknowledgments

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