RESPONSE TO THE OFFICE OF MEDICAL INSPECTOR SUPPLEMENTAL REPORT

March 13, 2023

OSC FILE NUMBER DI-21-00643 & DI-21-000651

REVIEW SUMMARY

Overall, our concerns continue to be related to contradictions, omission of pertinent information and bias towards the whistleblowers. The lengths to which the VA leadership go to paint the whistleblowers as poorly trained and the cause for some of the deficiencies brought forward in the complaint and investigation indicates a systemic problem with personal accountability and integrity with VA leadership. The inconsistencies further make it clear that the intent of the original OMI investigation and this supplemental report is/was to discredit the whistleblowers and not fully investigate the unsafe work environment. The significant mismanagement of the Endoscopy and Sterile Processing Service by the Veterans Health System of the Ozarks (VHSO) leadership, VISN-16 leadership, and the National Program Office for Sterile Processing continues to be the main concern of the whistleblowers.

A VA OIG report from 2018 contains the following information: High-quality sterile processing of reusable instruments and equipment is critical to patient safety, yet because of VA’s systemic mismanagement this has traditionally been difficult for the VA to consistently deliver. Over the past decade, the Office of Inspector General’s (OIG’s) oversight of VA facilities’ Sterile Processing Services (SPS) has revealed the systemic problems with VA leadership and its failure to correct the management of sterile processing operations and their ability to ensure consistent compliance with quality standards across its medical facilities. Multiple OIG reports underscore VA leadership’s ongoing failure to respond aggressively to reports of management failures within numerous individual facilities’ Sterile Processing Services. The OIG reports that the failure of VA medical facilities to correct critical deficiencies on such a large scale suggest fundamental defects in the VA’s organizational structure. Overall, the OIG consistently reports the breakdown of systems and leadership at multiple levels.

The whistleblowers have faced vicious retaliation when they tried to improve conditions in the department and hold managers accountable. The mental stress and physical injury caused by the VA’s poor leadership within the VHSO, VISN-16, and the NPOSP cannot be understated. There is an entrenched management culture that uses fear and intimidation to prevent whistleblowers from talking. The character assassination of the whistleblowers by leadership at various levels has had a drastic negative impact on the employees. Leveling unfounded and unsupported allegations against whistleblowers is a widely used tactic by VA leadership to shift blame and not take ownership of gross mismanagement. When employees say anything about patient care and the problems, these employees are quickly labeled as troublemakers and attacked by a group that just wants to promote and protect itself. The retaliatory tactics run the gamut from sophomoric to hard-to-fathom and more. The scope of the retaliation and sheer number of retaliation complaints across the VA agency should raise questions about whether the VA can adequately police itself and embrace whistleblowers. There is no accountability, and it will continue to be a never-ending cycle until someone steps in and starts cleaning house from the top and replacing these individuals with people who actually care about the veterans and employees.
OSC question #1 (abbreviated)

OSC Question: The report did not substantiate that the Gene Taylor Community Based Outpatient Clinic, Springfield, Missouri (Springfield), endoscopy sterile processing service (SPS) required an anteroom. However, the whistleblowers stated that in June 2022, the National Program Office for Sterile Processing (NPOSP), Veterans Integrated Services Network-16, and other safety offices discussed this issue and NPOSP acknowledged that an anteroom is required and the lack of one in the original SPS design was an oversight.

VA Response: (abbreviated) At the time of the design-build of Springfield and its endoscopy SPS suite, the Digestive Diseases-Endoscopy Service Design Guide, dated November 29, 2011, was used and did not require an anteroom. This was also the case at the time of the OMI investigation in September 2021.

Status: (abbreviated) At the time of the whistleblowers’ complaint and OMI’s investigation, no anteroom was required thus Allegation #4 remains unsubstantiated.

Whistleblower Comments: In a June 2022, phone conversation between the Springfield SPS supervisor (Whistleblower) and a Health Systems Specialist from the NPOSP, the Health Systems Specialist stated that he created the VA’s Endoscopy Design Guide, that ante rooms were in fact required, however it was an oversight on his part for not including ante rooms in the VA’s Endoscopy Design Guide. Further, the VA’s original report and this supplemental contain conflicting information. In question #1 the VA responded that at the time of the design-build the VA’s Endoscopy Design Guide was used and did not require ante rooms. In question #2 the VA responded that the VA used a non-VA design guide from Facility Guidelines Institute (FGI). Very contradictory, which one are we to believe they used? The VA’s design guide or FGI’s design guide? Also, if Fayetteville leadership had submitted design plans at the required intervals dictated by VA directive, then NPOSP would have identified design errors earlier during the construction, however, even when NPOSP received the design plans at approximately 50%, NPOSP only suggested changes to the sinks/eyewash station locations and little else. The collaboration the VA references for the remodeling of the Springfield SPS department started with a design developed by the whistleblowers and ultimately used by the very leadership that failed to ensure the Springfield SPS suite was designed correctly before and during the original construction. At the time of this writing the Springfield SPS supervisor (whistleblower) is working directly with the architect for the reconstruction project, because NPOSP, VISN 16, and VHSO leadership have ignored the architect’s repeated requests for design guide specifications. Who does this failure lay with?

OSC question #2

OSC Question: Please explain the Springfield endoscopy SPS suite redesign/remodel, as well as it’s implementation plan and timeline.

VA Response: (abbreviated) Springfield opened in 2018 and was designed and built largely following the Facility Guidelines Institute (FGI) design guidelines since it is a leased space. Fayetteville did not submit the Springfield SPS design plans at the required intervals per Veterans Health Administration (VHA) Directive 1116(2), Sterile Processing Service (SPS), dated March 23, 2016; if Fayetteville had done so, VA would have been provided the opportunity to include VA design specifications in the construction.

Status: This action is ongoing. The expected completion date of the reconstruction is estimated to be Summer of 2023.
Whistleblower Comments: The VHSO leadership, VISN-16 leadership, and the NPOSP failed to follow VA directives requiring review/approval for construction/renovation plans. This supplemental report supposes that if the directive had been followed the Springfield SPS suite would have been built correctly. We will never know. The NPOSP did have the opportunity at approximately 50% to review the plans and NPOSP suggested changes to the sinks/eyewash station locations and little else. Why didn’t NPOSP include complete design specification then? The Supplemental report also wants to place blame on “Springfield” for “failure to fully implement VHA Clinical Design Guide requirements that led to the potential for a risk of cross-contamination of endoscopes due to non-linear workflow and the lack of an appropriate clean scope storage area.” This is another gross misstatement by the VA. The failure lays solely with the VHSO, VISN-16, and NPOSP leadership who were negligent in the conduct of their duties and responsibilities. The potential for cross-contamination and non-linear workflow was caused by VHSO leadership making unauthorized/unapproved changes to the design, square footage, and space for the Springfield SPS decontamination room. Other unauthorized/unapproved changes included reallocating space that was dedicated for reprocessing used dental instruments. Because of this, dental instruments must be transported between the Springfield, Missouri CBOC and the VA’s Medical Center located in Fayetteville, Arkansas via a private courier company. These unauthorized/unapproved changes crippled the functionality of the Springfield SPS department and now taxpayers pay for contract courier services that wouldn’t be necessary had VHSO leadership not taken space away from the SPS department. Who does this gross mismanagement lay with?

OSC question #3

Further, please provide the status on the report’s fifteen recommended corrective actions.

Recommendation #1 to Fayetteville: Provide training and education to facility industrial hygiene and safety staff and facility management staff regarding when a hazard assessment, including an eyewash and emergency shower risk assessment is required consistent with Veterans Health Administration (VHA) Directive 7704, Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment dated February 16, 2016.

VA Response: Education will be provided to pertinent staff (facility industrial hygienist, safety staff and management) regarding when to perform hazardous assessments with emphasis on eyewash and emergency shower risk assessments in alignment with VHA Directive 7704, Emergency Eyewash and Shower program, dated October 12, 2021.

Status: This action is ongoing. The expected completion date is February 1, 2023.

Whistleblower Comments: In the writing of this supplemental report, as well as the original report, the VA wants the reader to believe adequate measures are being taken to correct the deficient actions of the leadership/management officials/senior employees who failed to do their jobs within the requirements of VA directives. The VA will use the word “remedial” as it pertains to what they say is needed and planned for the employees/whistleblowers but nothing of the sort for the leaders who’s negligence caused the Springfield Endoscopy and SPS department to only be open 5 months out of the 4 years the CBOC has been open. These leaders are responsible for the gross mismanagement and waste concerning the construction of the Springfield SPS department.
**Recommendation #2 to Fayetteville:** Provide refresher training for all Springfield SPS staff regarding appropriate PPE attire consistent with VHS Directive 1116(2), Sterile Processing Services (SPS), and VHA-V16-564-SOP-1013. Monitor compliance with in-person rounding and address noncompliance as appropriate.

**VA Response:** Since SPS operations are still suspended at Springfield pending the reconstruction, the refresher training regarding appropriate PPE attire has not yet occurred. This training will occur prior to reactivation following the reconstruction. The training plan includes the following:

- Conducting remedial training with all Springfield SPS staff on VHA-V16-564-SOP-1013, to include completion of competency assessment.
- Conducting remedial training with all Springfield SPS staff on VHA Directive 1116(2) with emphasis on infection prevention and control and safety. Remedial training will be conducted by means of in-service and captured via training record.
- Following training, the Quality, Safety and Value (QSV) Service will perform random tracers/observations at the Springfield SPS for compliance with regulations, standards and national requirements. QSV Service will continue to maintain the records for these tracers/observations and immediately report all non-conformities to the Chief of SPS for remediation.
- In collaboration with the QSV Service, Fayetteville SPS Management will perform tracers/observations at Springfield during biweekly-monthly rounding and report findings (non-compliance) to the Associate Director of Patient Care Services and Chief Nurse of QSV.

**Status:** This action is ongoing. The expected completion date is unknown pending reconstruction of the SPS area.

**Whistleblower Comments:** The implication that remedial training is needed or warranted for the employees is totally off base. The VISN-16 SPS Lead inspected the Springfield SPS twice just prior to opening in April 2021. No deficiencies were noted for any competencies. The VA also wants to imply that the employees/whistleblowers were not in compliance with PPE requirements. Inspection and audit results by Fayetteville Quality Safety Value prior to opening in April 2021 generated the following comment: “The staff of SPS is very organized and neat, and were able to speak to each step of the process. They also had their SOP open and ready for reference. They were cooperative and ready to answer all of our questions as we followed their process.” All the false allegations against the whistleblowers in this supplemental report as well as the original OMI report were brought forward by the Assistant Chief of Fayetteville SPS, who retired early shortly after the Springfield Endoscopy department was closed. There were no negative counseling or personnel action to support his claims that Springfield SPS refused to wear required PPE. Further, Springfield SPS MSTs have consistently received outstanding evaluations and performance bonuses. However, the SPS MST supervisor/whistleblower has received negative performance evaluations because of the whistleblower disclosures. To punish and humiliate the whistleblowers, leadership detailed the whistleblowers to Environmental Management Service as Housekeepers, this is currently being investigated by OAWP and OSC as retaliatory acts.

**Recommendation #3 to Fayetteville:** Review and correct the temperature, humidity, air exchange and air flow issues in the endoscopy suite and ensure alignment with appropriate guidelines.
VA Response: (abbreviated) A full test and balance of the temperature, humidity, air exchange and air flow within the endoscopy suite is included within the Statement of Work (SOW) for the reconstruction modifications to the suite.

Status: This action is ongoing. The completion date is unknown pending the reconstruction of the SPS area.

Whistleblower Comments: None.

Recommendation #4 to Fayetteville: Check spaces around all CBOC thermostats to ensure devices are making accurate readings and relocate the printer in the endoscopy patient holding bay away from the thermostat.

VA Response: (abbreviated) Fayetteville issued a request for information (RFI) to the Springfield lessor maintenance staff to assess the conditions of each thermostat, to ensure each were operating correctly and that devices were not being impacted by nearby equipment or conditions that may be negatively influencing system operations.

Status: This action is ongoing. The expected completion date is unknown pending the reconstruction of the SPS area.

Whistleblower Comments: None.

Recommendation #5 to Fayetteville: Place the CheckPoint devices on a preventative maintenance schedule and calibrate them to ensure the measurements being taken are accurate.

VA Response: (abbreviated) The Engineering Service staff added changing the batteries of CheckPoint monitoring devices to their preventive maintenance schedule on an annual basis and will also address this need when identified by the software system.

Status: This action is complete and closed as of May 9, 2022.

Whistleblower Comments: None.

Recommendation #6 to Fayetteville: Review the air handler unit number 8 to determine if the minimum efficiency reporting value 14 Filter can be relocated and another Prefilter installed. Additional pressure differential monitors in air handler unit number 8 would also be required to ensure the proper air flow is occurring.

VA Response: The contracting officer’s representative directed an RFI to the Springfield site’s lessor to correct the air filters on air handler unit number 8. The lessor installed a new filter rack to the existing area to provide space for the specified filters which were installed. The air handler was placed on a quarterly PM schedule to monitor performance to ensure that proper air flow is occurring.

Status: This action is complete and closed as of September 30, 2022.

Whistleblower Comments: None.

Recommendation #7 to Fayetteville: Relocate the pressure differential monitors so that they are closer to the entry points, as well as adding an additional monitor over the pass-thru window to ensure accurate readings.
**VA Response:** The SOW includes the following modifications of the design of the Springfield endoscopy SPS suite:

- Relocate the pressure differential monitors in the Decontamination and Scope Reprocessing Rooms closer to each room’s entry points to improve SPS staff’s visibility of the device readings.
- Add an additional pressure differential monitor above the pass-thru window that connects the two rooms to ensure accuracy of readings.
- Add the construction of an anteroom to control pressure when the door is opened.

VA staff will consistently review the design and reconstruction phases and collaborate with the building’s lessor to ensure the proper locations of the pressure differential monitors.

**Status:** This action is ongoing. The expected completion date is unknown pending the reconstruction of the SPS area.

**Whistleblower Comments:** None.

**Recommendation #8 to Fayetteville:** Cease SPS endoscopy reprocessing operations at Springfield until the workflow, endoscope storage issues, potential for cross-contamination, sink locations, PPE compliance, and temperature/humidity/air flow issues are corrected.

**VA Response:** All endoscopy procedures and SPS decontamination and reprocessing operations were ceased at Springfield on October 1, 2021. The proposed design to reconstruct the Springfield endoscopy SPS suite to mitigate environmental and workflow non-conformances was reviewed and approved by the NPOSP and HEFP in August 2022. The reactivation of the space is pending the reconstruction.

**Status:** This action is ongoing. The expected completion date is unknown pending the reconstruction of the SPS area.

**Whistleblower Comments:** None.

**Recommendation #9 to Fayetteville:** Consult with the NPOSP for their expertise in addressing the SPS concerns.

**VA Response:** The Associate Director for Patient Care Services submitted the SOW draft, which addressed the environmental and workflow non-conformances, to the VISN 16 SPS Lead and NPOSP in April 2022 for review, consultation and approval. The proposed design to reconstruct the Springfield endoscopy SPS suite was approved by NPOSP in August 2022. Ongoing consultation with NPOSP will occur as needed during and after reconstruction.

**Status:** This action is ongoing. The expected completion date is unknown pending the reconstruction of the SPS area.

**Whistleblower Comments:** The VISN-16 SPS Lead conducted 2 inspections of the Springfield SPS department. On one inspection the VISN lead was accompanied by a Chief of SPS from another medical facility. No deficiencies were noted. In a text conversion with a whistleblower after these inspections and the endoscopy department closure a QSV representative stated “I was told that Endo/SPS may not open again if these process issues were not corrected. It’s proof to me that (name redacted, VISN-16 SPS Lead) and (name redacted, SPS Chief of Little Rock VA) were wrong about their final assessment.”
**Recommendation #10 to Fayetteville:** Consult with the Healthcare Environment and Facilities Program to assist with the correction of the temperature/humidity/air flow issues.

**VA Response:** Proposed modifications to correct pressure issues were coordinated with the HEFP compliance engineers; approval to proceed was received. The SOW was drafted with the proposed modifications and submitted, reviewed and approved by the engineers. Temperature, humidity and air flow requirements are included in the proposed renovation plans of the Springfield endoscopy SPS suite.

**Status:** This action is ongoing. The expected completion date is unknown pending the reconstruction of the SPS area.

**Whistleblower Comments:** None

**Recommendation #11 to Fayetteville:** Perform a clinical review of all completed endoscopy procedures (up to 30 days post-procedure) performed since the inception of services (April 27-October 1, 2021). Determine if any procedures resulted in complications or infections, ensure the Veteran has received the appropriate care and perform a clinical or institutional disclosure as indicated.

**VA Response:** Fayetteville quality management staff conducted a clinical review of all completed endoscopy procedures performed from the inception of services on April 27, 2021, through the halting of procedures on October 1, 2021. All Veterans were followed for 30 days post-procedure to determine if any complications, infections or other negative impacts to patients had occurred. Of the 343 procedures, none resulted in any complications, infections, or other negative impacts to patients who received care.

**Status:** This action is complete and was closed as November 1, 2021.

**Whistleblower Comments:** Even with the significant deficiencies caused by poor leadership the Springfield SPS staff made every attempt to accomplish their mission as professionally as possible. The staff also tried to address the issues in this complaint at each level of leadership within the VHSG without any success. Leadership at each level were adamant that there were no issues with the Springfield SPS department. The professionalism of the Springfield staff is supported by a portion of the VA’s own response “Of the 343 procedures, none resulted in any complications, infections, or other negative impacts to patients who received care.”

**Recommendation #12 to Fayetteville:** Evaluate the need for an increased leadership and supervisory presence at Springfield.

**VA Response:** A staffing analysis was completed to determine the need to increase leadership and supervisory oversight at Springfield. The facility is collaborating with the VISN 16 SPS lead and NPOSP to review the findings of the analysis and to determine the appropriate SPS Supervisory presence at Springfield moving forward.

**Status:** This action is ongoing pending review of the staffing analysis with the VISN 16 SPS Lead and NPOSP. The expected completion date is February 1, 2023.

**Whistleblower Comments:** None.
**Recommendation #13 to Fayetteville:** Review the functional statement and job duties of the GI Assistant Nurse Manager to ensure the role has appropriate oversight and authority of the Springfield GI Department.

**VA Response:** The functional statement and job duties of the Gastroenterology (GI) Assistant Nurse Manager were reviewed by Fayetteville nursing leadership and updated to ensure the role includes providing appropriate oversight of the Springfield GI Department. A request was approved to change the role to a Nurse Manager for GI Endoscopy and Specialty Clinics. The functional statement and role classification update is in progress. Following the update, recruitment efforts will be initiated.

**Status:** This action is ongoing pending the completion of the updated functional statement. The expected completed date is February 1, 2023.

**Whistleblower Comments:** None

**Recommendation #14 to Fayetteville:** Provide education to SPS leadership and Facilities Management personnel involved with construction planning regarding the requirements described in VHA Directive 1116(2) and ensure all future SPS plans for construction are submitted at the required intervals per the directive and the recommendations received from NPOSP are followed.

**VA Response:** Construction planning submission requirements are the responsibility of Fayetteville’s Facility Planner. The Facility Planner was provided education regarding the requirements of VHA Directive 1116(2) and has been instructed to ensure all future SPS plans are approved at the required intervals. In addition, Fayetteville leadership, Facilities Management and SPS leadership have been instructed to ensure all future SPS plans for construction are submitted at the required intervals per VHA Directive 1116(2).

**Status:** This action is complete and was closed as of September 30, 2022.

**Whistleblower Comments:** None.

**Recommendation #15 to Fayetteville:** Provide training to all Springfield staff on VHA Worker’s Compensation Program Guidebook and Fayetteville MCP 00-17, including reporting injuries or illness as soon as possible to the affected employee’s supervisor and completion of OSHA Form 301. Ensure supervisors investigate and find the cause of the accident or illness immediately upon notification by an employee and take necessary corrective and preventive measures to eliminate the cause of the accident.

**VA Response:** An online training course about VHA’s Worker’s Compensation Program Guidebook and Fayetteville’s Medical Center Policy 00-17, Safety Occupational Health and Fire Protection Rules and Procedures, dated April 6, 2021, has been assigned to all Springfield staff via the Talent Management System. This includes appropriate reporting of workplace injuries and/or illness to the employee’s Supervisor and/or Service Line Chief, the Employees’ Compensation Operations & Management Portal process and how to file an Occupational Safety Health Administration form 301.

**Status:** This action is ongoing pending the Springfield staff’s completion of the training course. The expected completion date is February 1, 2023.
**Whistleblower Comments:** Incidents and accidents were reported in accordance with directions received from leadership.

**Conclusion:** While the whistleblowers receive the news of a complete remodel of the SPS department with optimism the continued negative conduct of the VA leadership is very concerning. This is supported by the following statement made by the VA OIG from 2018: “Over the past decade, the Office of Inspector General’s (OIG’s) oversight of VA facilities’ Sterile Processing Services (SPS) has revealed the systemic problems with VA leadership and its failure to correct the management of sterile processing operations and their ability to ensure consistent compliance with quality standards across its medical facilities. The multiple OIG reports underscore the VA leaders ongoing failure to respond aggressively to reports of management failures within numerous individual facilities’ Sterile Processing Services.”

The treatment of the whistleblowers by VA leadership has been abhorrent and even with multiple complaints the same treatment continues to this day. The mental stress and physical injury caused by the VA’s poor leadership within the VHOSO, VISN-16, and the NPOSP cannot be understated. The character assassination of the whistleblowers by leadership at various levels has had a drastic negative impact on the employees. Leveling unfounded and unsupported allegations against whistleblowers is a widely used tactic by VA leadership to shift blame and not take ownership of gross mismanagement. When VHOSO leadership makes conscious decisions to not support a department this has a significant impact on veterans and veteran employees. Intentionally being provided broken equipment or no equipment, when it’s requested, has significantly impacted the SPS employees. Veterans are being sent out through community care and wait in the que at civilian hospitals. This action extends the time to procedure for the veterans and negatively impacts the caseload of the local hospitals.