

**U.S. Office of Special Counsel  
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**Response to Investigation to the U.S. Office of Special Counsel  
OSC File Number DI-11-2518**

In response to the Department of Veterans Affairs' final report of investigation of allegations levied against the G. V. (Sonny) Montgomery Veterans Medical Center in Jackson, MS.

On August 17, 2011 in response to a message left by Mr. Tommie Stuart on August 15, 2011, I returned his call and was informed that he had been appointed as the lead inspector of the investigative team that would be investigating the allegations that I had made to the Office of Special Counsel (OSC). I was asked if I would take part in a telephone review of the allegations with the other members of the team scheduled for August 18, 2011. Mr. Stuart then asked me about my availability for the following week. I stated that I would be available at anytime to take part in the investigation. On August 18, 2011, Mr. Stuart stated that he wanted to go through the twenty seven (27) allegations that he had for accuracy and provide me with an opportunity to provide any other information that warrants investigation. During the sixty two (62) minute conference call, I verified the accuracy of the 27 specific allegations and included others. On August 25, 2011, Mr. Stuart left me a voice message stating that he has everything that he needs, will not need to interview me and that if I have any questions that he will be back at his office on Tuesday.

There is a wall which separates the Decontamination area from the Preparation area as indicated however, it doesn't prohibit nor prevent a Medical Supply Technician (MST) from leaving the area into the general population. Although the exit for reprocessed reusable medical equipment (RME) is located in the Preparation area, this wall in no way prevents the MST from leaving the Decontamination area with contaminants on their person and property.

Staff in the Decontamination area would routinely receive calls on their cell phones; answer their phones while sometimes wearing the same gloves used in the reprocessing of reusable medical devices (RME) before the interruption. Not only was jewelry worn in the area, romance paperback books were taken into the area to read, and candy taken and eaten in the area by veteran technicians were commonplace.

The assertion that "the rationale behind regulating what the Technicians wear within the Decontamination area is to protect the Technicians and their property" is partially accurate. The other aspect of it is that non compliance in the wearing of PPE presents a real and imminent danger for the transmission of infectious microorganisms to infect the technicians as well as being transferred throughout the facility to patients, staff, visitors, and family members from contaminated staff in SPD via direct and indirect contact.

The depiction of the layout of the Decontamination area has been explained fairly well with the exception of an unrestricted unsecured entrance that leads into and out of the Decontamination area that allows for anyone in from the areas of Logistics and SPD to gain direct access to come and go at will. The unsecured door is located in the Distribution area and leads directly into the room where case carts are stored after exiting the automated case cart washer. To the left of the case cart exit door is yet another unlocked door which leads into a narrow room about 10 to 12 ft. long used to power wash medical equipment which directly leads into the Decontamination area. This entrance is routinely used by Decontamination staff to gain direct entry into the Decontamination area bypassing the anteroom where PPE is only supposed to be stored for usage in the Decontamination area. Upon entry into the Decontamination area via said route, there is a space located directly behind the computer, which is separated by a wall, on the back side of this wall stands a wire shelf where Decontamination staff maintains a supply of PPE along with a stool to sit on while donning their shoe covering. This is the same entrance often used by the Decontamination staff upon return to the area after leaving SPD staff meetings.

Yet, Decontamination staff would leave the area via the door leading into the anteroom wearing the same gowns wore while in the Decontamination area to make their morning rounds picking up equipment throughout the hospital wards. This is the common practice of the staff. These occurrences took place during my rotation in the Decontamination area in February of 2010. At least three (3) times a day I was in the Acting, SPD Chiefs office discussing what was occurring in the area and how critical it to have the supervisor actually supervise the staff. I informed her that every wrong way to perform tasks in Decontamination is being performed by everyone back their. And all I hear is that this is the way we've been taught. The SOPs contained in binders were actually dusty and it was evident that the SOPs were not being read. There were several contract employees reprocessing RME without having had any prior training or even reading the SOPs. The contract employees had been shown what to do and how to do it by the "veteran", experienced employees.

Additionally, there is a sliding glass window sitting atop of a conveyor belt which lifts in an upward/downward direction that is separated by the two areas. The intended purpose of having this window is that it allows the Medical Technicians in the Preparation Area to return soiled instruments received from the washer/disinfector which have completed the decontamination reprocessing cycle and have exited into the Preparation area but are been found to have some visible form of debris left behind necessitating the device to be returned to Decontamination for reprocessed again via the sliding glass window.

On those rare occasions when the window was actually used for its intended purpose, Decontamination staff would return the instrument to the Preparation by simply handing it though the window while wearing the same gloves worn to clean the instrument to the Medical Technician in the Preparation area. This practice is extremely dangerous as any 1) the instrument hasn't been subjected to the appropriate cleaning protocol in its entirety; manual cleaning and washer/dissenfector per the manufactures instructions for use (IFU) to remove residual bioburden and cleaning solutions to ready the medical device for the sterilization process, 2) since Medical Technicians are not required to wear gloves when handling the instruments processed in Preparation area any contaminates left on the device will be transferred onto their hands and to subsequent instrumentation they are working on at that time, and 3)

compromises the integrity of the sterilization process of the medical device and ultimately places patients at risk of contamination.

It was not uncommon to see Decontamination staff through the window from the Preparation area standing at the sink in the Decontamination area cleaning instruments not only above the water line as required but, above the sink level without the use of face shields. Splashes or sprays of blood, body fluids, or other infectious materials generated during these reprocessing activities left personnel unprotected from contact with large infectious droplets of microorganisms and body fluids generated.

Although it is required that this window remain shut at all times except for the short duration of time required to place the medical device on the other side of the window and close it, the Medical Technicians would routinely leave this window wide open because it allowed a cool breeze to flow into the Decontamination Area. This is a dangerous practice as it allows for aerosolization of contaminated water droplets to be dispersed into the air and into the Preparation Area, the process area where the inspection, assembly, packaging, wrapping, and sterilization occurs. This poses another risk of bioburden being transferred onto the Medical Technician in the Preparation Area and also lends itself to the contents of the instrumentation tray being compromised with residual organic matter. When the Medical Technicians and their property become contaminated, leave the decontamination area and migrate into the public domain; contaminated and with their contaminated articles, so too will anything or anyone who may come into contact with said contaminated individuals with bio hazardous waste product which now has been introduced into common areas such as the hospital corridors, cafeteria, canteen, employee break area, etc. Thus, creating optimum conditions for cross contamination and placing patients, staff, and visitors at risk of becoming the next object of contamination. The investigative team failed to address this issue in the report.

Required in each tray is an Instrument Tray packing list; count sheet, the list specifies which and how many of each item should be included on the instrumentation tray. Upon completion, the technician responsible for pack preparation initials the indicator tape used to seal the tray prior to sterilization. This provides accountability and a mechanism for facilitating problem identification and corrections. However, during my rotation in the Preparation area in July 2010 while working with another Medical Supply Technician putting together instrumentation trays, I observed that none of the staff were actually inspecting the instruments for cleanliness, flaws, damages, or even functionality prior to placing them onto the tray. Rather, the standard practice was that once a technician had completed the assembly of a tray, another technician was asked to sign off on the count sheet to indicate that it had been verified for accuracy via inspection by that second technician although that had never occurred.

For example, to illustrate this, as a result of the OSC Investigation File No. DI-09-3272 in October 2009, there was only one Medical Technician identified as having prepared and inspected the instrumentation tray that contained a rigid metal suction tube found to have had debris in it. It was recommended that this individual receive a 14 day suspension. However, the Lead SPD Technician had also signed the count sheet indicating that she also had inspected the tray thus validating the accuracy and functionality of the contents even though she had not. Yet, her name was never mentioned as it should have been nor any disciplinary action taken against

her. It should also be noted that no one in the Decontamination area was held accountable for not having cleaned the device in the beginning of the reprocessing protocol. It was a routinely disparity in punishment and the lack there of.

Cleaning refers to the removal of all visible and non visible soil, and any other foreign material from the RME being processed. It is the most important step in the disinfection and sterilization process. Instruments must be cleaned and rinsed for subsequent steps to be effective. After cleaning, the steps involved in reprocessing are critical to the safety of everyone handling the instruments. The manufactures instructions for use (IFU) provides detailed instruments on the how to reprocess medical devices which includes diagrams and illustrations of the instrumentation. "Hard-to-find" places is tantamount to a game of "hide and go seek" for the bone fragment, which is behavior clearly indicative of some one lacking training and experience. Additionally, a drill bits isn't a hard to find place, rather it is a component part used in a power drill. During rotation to the OR in May/June 2010, the Surgical Technicians would remove debris throughout the course of the orthopedic cases and after the procedure; the Surgical Technician would remove the drill bit from the power drill before it was transported to Decontamination for further processing. Utilization of a stiff, non-metal and paying close attention to crevices and hard to reach areas such as seams, joints, triggers, and connectors for tissue or bone fragments is paramount in the cleaning process. Inspecting for cleanliness and proper working order is the step following the cleaning and decontamination protocol, unfortunately, this critical step just doesn't occur due to a major training deficiency in SPD.

The senior SPD staff are stuck in their ways of reprocessing RME based on what they had been taught pre-IFU and have been resistant to change. Now, here come the new employees to SPD and are already emulating their senior counterparts. If the instrument cannot be cleaned, it cannot be used.

The specific allegation as stated to the investigative team during a telephone conversation on August 18, 2011 and in written correspondence sent via email to the Nurse Executive, Dr. Dorothy White-Taylor, and Medical Center Director, Ms. Watson on July 28, 2010 was that numerous attempts of PPE non compliance had been brought to the attention of the (Acting) SPD Chief, Joan Simon however, she repeatedly told me that the "Front Office" is aware of this situation but refuses to take any action. Whether this true or not, the fact is that Decontamination personnel were jeopardizing the health, safety, and well being of self, co-workers, customers, and patients at this facility by not wearing any facial shields, goggles, or masks while inside the Decontamination area. Additionally, some of the staff were donning; putting on, PPE once inside Decontamination, and are wearing outer covering retrieved from with Decontamination and wearing it throughout the facility.

However, whenever there was an inspection, assessment, or review of any kind from any outside entity, the full PPE was donned in its entirety. If management actually reinforced the correct wearing of PPE at all times and took the appropriate actions deemed necessary to provide personnel adequate training, PPE compliance would therefore exist however, it doesn't. It has been and still is an on-going problem.

During my rotation in the Gastrointestinal (GI) Clinic in March 2010, PPE was being stored in the Decontamination area where endoscopes are reprocessed and PPE was being donned by personnel once inside the area. Personnel in the department were advised and the situation discussed with the Acting, SPD Chief and GI Nurse Manager, however, nothing changed. Subsequently, email correspondence was sent to the Acting, SPD Chief and GI Nurse manager, with no positive results. The VISN SPD Program Manager conducted a pre SOARS Assessment visit and cited the facility for having PPE stored in the GI Decontamination area. It was purported to have been rectified yet, during the actual SOARS Assessment, it was a finding. After which there was action taken to remedy the problem. It should be noted that as far back as November 2008 during the IPDO inspection of SPD the same finding was noted, yet no action had been taken. Senior management has chosen to blatantly disregard VA, VHA, OSHA, The Joint Commission (TJC), etc. policy guidelines over a series of years and this places everyone at the facility in grave danger and greater risk of becoming infected with contaminants transported throughout the facility by noncompliant personnel.

On August 18, 2011 during that telephone review of the allegations, it was disclosed to the Team that there was no leadership, guidance or supervision of personnel and that the SPD Supervisory position has been vacant since the December 2010 retirement of the former supervisor. The very next day, August 19, 2011, a position announcement appeared on USAjobs.gov for the vacant SPD Supervisory position. However, the position was subsequently filled by an employee without any prior supervisory experience or skills.

Additionally, it was stated that SPD doesn't have a training program or anyone in SPD leadership with the requisite knowledge to plan, develop and execute an effective training program. I stated that the cross training of personnel hadn't occurred although it was reported to have been 75% complete and that is the reason why I had developed the color coded training Matrix to illustrate who has been trained, when the training occurred, on what RME, and competency validations performed. The information showed that the majority of SPD staff were not cross-trained and many working within their functional areas didn't have the training required to reprocess RME that were being routinely processed to include the SPD Supervisor.

The Lead Investigator, Tommie Stewart asked me if SPD Level I training was being done. SPD Level I training program which should be administered to a new SPD employee during the initial orientation and is required that it must be completed. It is now an automated course which consists of 10 modules with an end of module test in which a score of 80% or better is required before allowing you to continue on to the next module until all 10 modules have been successfully completed. I informed the Team that Level I training has taken place but, it wasn't being performed individually as it required to be done. Instead the SPD staff was having difficulties achieving the required score of 80% on the module along with the Acting, SPD Chief so they decided to work as a group to obtain the answers so that they may go back individually with the answers derived collectively and complete the modules although.

The multiple in-service education training sessions documented should in no way be perceived as a factual indicator that the actual training occurred in every instance. During staff meetings, the Acting SPD Chief, Joan Simon, would circulate multiply sign in sheets where the general purpose training record portion of the form would be blank and everyone was instructed to sign

the sheets as they were passed around. After the staff meetings had concluded the Acting SPD Chief would write in various training course titles which would be later used to show as proof that training had occurred when in fact, it had not occurred. Additionally, copies of standard operating procedures (SOPs) were routinely passed out to the employees during staff meetings along with a sign in sheet for everyone to sign which was to indicate that training on the procedures had taken place when in fact training hadn't occurred. Therefore, documented inservice education sessions isn't necessarily indicative of a factual pattern of continuing training for staff, nor conducive to SPD staff having been exposed to or acquire the requisite knowledge.

The Acting, SPD Chief would sit in her office and have competency assessment documents pre-filled and staff from the Decontamination area would come into her office and she would say "I know that you know what you're doing, sign and date here".

Now there are approximately thirteen (13) Medical Supply Technicians (MSTs) assigned to the Decontamination Unit. Six (6) work in satellite locations throughout the hospital; Ears Nose and Throat (ENT), Gastrointestinal, (GI), and Respiratory and the remaining seven (7) MSTs work in the Decontamination area located in SPD. At 7:00 a.m., there are four (4) MSTs assigned to duty in the SPD Decontamination Unit. By 10:00 a.m., there are five (5) MSTs on duty and at 12:00 p.m., there are a total of seven (7) MSTs in the Decontamination area. All of whom had not been educated and properly trained to execute the functional tasks in their position.

On July 29, 2010 Susan Scott-Williams; SPD Program Manager and Quality Assurance Specialist; Chad Butler entered the SPD Supervisor/Lead SPD Technician's office where I had been engaged in a conversation with the Lead SPD Technician; Martha (Lynn) Harris. We greeted one another and I then asked Ms. Scott-Williams what brought her to our neck of the woods. She stated that she and Ms. Myrtle Tate were at the facility to verify that SPD has manufacturer's instructions for 100% of all the reusable medical equipment (RME) that is in use and being reprocessed at the facility. Ms. Harris asked, "Today!" and Ms. Scott-Williams replied with, "Yes, Today!" Ms. Scott-Williams proceeded to ask me if the binder contains all the instruments that are reprocessed by SPD. I stated that I wasn't aware of the binder that she was referring to and that I would have to take a look at it. So, Ms. Scott-Williams, Chad Butler and I went to the Acting, SPD Chief's office; Joan A. Simon-Absent, were the Ms. Myrtle Tate; VISN Inspector, and the Asst. Chief, SPD; Carla Acosta. Ms. Tate and I greeted one another and then Ms. Scott-Williams informed Ms. Tate that I would be looking in the binder to determine if it contained a listing of all the RME in use by SPD. I opened the binder and began turning the pages of the listed RME presumed to be reprocessed in SPD. Ms. Tate asked me if all the RME was listed and I stated to her that it wasn't. Ms. Tate then asked Carla Acosta if that was all the RME being reprocessed at the facility and Ms. Acosta stated, "Yes it is". Ms. Tate then asked Mr. Butler if that is all the RME that is being reprocessed at the facility and he stated, "Yes it is". Ms Tate then asked me if I had another document with all the RME listed, I said, "Yes and that I needed to go back to my office to get it. After returning to my office, I had difficulty in printing the document with clarity due to the ink cartridge needing to be replaced however, I decided to email the document to Ms. Tate and Ms. Scott-Williams. I then took the document that I had printed and proceeded back to SPD. Upon my return to the Acting, SPD Chief's office, the door was closed and Carl Acosta, Assistant, SPD Chief said to me, "Dr. Taylor said not to go in that

office and give them that list. I left the area and returned within 10 minutes and met Dr. Taylor in the hall, she immediately took the document from my hand and said, "They don't need this, they don't know what they are doing or looking for. This is a white man's attempt to use a black person to take down another black person". This is what actually transpired.

Subsequently, I made the same disclosures to Mr George Gray; VISN Director on July 29, 2010 of Dr. Dorothy Taylor-White's; Associate Director, Patient Care Services attempt to conceal evidence that would show reusable medical equipment (RME) was not be reprocessed in accordance with manufacturer's guidelines because the Jackson VA didn't have all the guidelines required for all the RME in use at the facility.

Had I been given the opportunity to testify during the investigation, I would have been able to provide the Team with evidence to show that I was the only person involved in the development and construction of the RME binder.

Office of the Medical Inspectors visited the facility in October of 2009 due to an anonymous complaint received. Many of the employees interviewed were reluctant and failed to provide information concerning problems experienced in receiving clean instruments from SPD due to a real fear of retaliation from management. A team of handpicked stooges by the upper echelon of management were chosen to shadow the investigators and record any and everything that anyone had to say to the inspectors and report back to them.

Shortly after having returned to my office from the interview with the inspectors, I received a call from Dr. Taylor-White to come to her office. Upon arrival, she asked me about my interview with the inspectors, what they asked me and what I told them. She then proceeded to tell me that I needed to go to the conference room and get Mrs. Watson out of the meeting to provide her the details of my interview with the inspectors. I was disturbed and appalled at the arrogance and blatant disregard for the integrity and respect of the investigative process. I gave both Dr. White-Taylor and Mrs. Watson a vague overview of benign information which I had hoped would quash the subject matter. However, much to my chagrin, Dr. White-Taylor requested that everyone who spoke with the investigators to provide, in writing, our conversation with the Medical inspectors for Mrs. Watson. She sent the request via email and unfortunately I deleted it. However, I believe that it is possible for deleted files to be retrieved by OIT. However, that email sent to me by Dr. Dorothy White-Taylor had also been sent to Acting, SPD Chief, SPD Supervisor, and the Lead SPD Technician.

The Occupational Safety and Health Act is the primary federal which governs occupational health and safety in the private sector and federal government in the United States. It was enacted by Congress in 1970 and was signed by the President on December 29, 1970. Its main goal is to ensure that employers provide employees with an environment free from recognized hazards, such as exposure to toxic chemicals, excessive noise levels, mechanical dangers, heat or cold stress, or unsanitary conditions. In passing the Act, Congress declared its intent "to assure so far as possible every working man and woman in the Nation safe and healthful working conditions and to preserve our human resources.

Executive Order 12196, Occupational Safety and Health Programs for Federal Employees, issued on February 26, 1980, prescribe additional responsibilities for the heads of agencies. Executive Order 12196 and these basic program elements apply to all agencies of the Executive Branch. They apply to all Federal employees. They apply to all working conditions of Federal employees except those involving uniquely military equipment, systems, and operations. As such, it applies to the Veterans Health Administration (VHA).

Section 19 of the Occupational Safety and Health Act (the Act) contains the special provisions to assure safe and healthful working conditions for Federal employees. Under that section, it is the responsibility of the head of each Federal agency to establish and maintain an effective and comprehensive occupational safety and health program which is consistent with the standards promulgated under section 6 of the Act which can be found in the United States Code at title 29, chapter 15.

In response to Public Law (Pub. L.) 91-596; the Occupational Safety and Health Act of 1970, Section 19, the Veterans Health Administration (VHA) established a VHA Occupational Safety and Health (OSH) Program procedures; VHA Handbook 7701.01. The purpose of this Agency policy is that it establishes mandatory procedures and standards for the VHA OSH Program. The authorities to implement the VHA OSH Program are found in:

- 1) Public Law (Pub. L.) 91-596
- 2) Executive Order (E.O.) 12196, OSH Programs for Federal Employees and the Occupational Safety and Health Program.
- 3) Title 29, Code of Federal Regulations (CFR), Part 1960, Basic Program Elements for Federal Employee OSH Programs and Related Matters
- 4) Department of Veterans Affairs (VA) Directive 7700
- 5) VHA Directive 7701 & 7701.1

The objectives of the VHA OSH Program are to provide a safe and healthful work environment for all VHA employees and volunteers and to ensure compliance with Federal regulations, Executive Orders, VA, and VHA policies, etc.

PPE is specialized clothing or equipment worn by a worker for protection against a hazard. The hazard in a health care setting is exposure to blood, saliva, or other bodily fluids or aerosols that may carry infectious materials such as Hepatitis C, HIV, or other blood borne or bodily fluid pathogen. PPE prevents contact with a potentially infectious material by creating a physical barrier between the potential infectious material and the healthcare worker.

However, in the absence of this critical barrier, workers and their property are directly exposed to the infectious material and they themselves as well as their property then becomes the vessel carrier of transporting bioburden throughout the facility and environment. Potential exposures to hospital staff will usually result from proximity to, or contact with someone whose skin and/or clothing and objects such as watches, earrings, cell phones, purses, etc. which may have become contaminated. Cell phones falls under the category of being an item, as such, any item taken into the Decontamination area must be considered contaminated which is addressed in VA Handbook 7176 Part 6, paragraph 7.607b.

PPE is not an option; it is an OSHA requirement, according to CFR 1910.1030(d)(3)(ii) of the Bloodborne Pathogens standard. Standard Precautions is a combination and expansion of Universal Precautions and Body Substance Isolation. Standard Precautions is based on the principle that all blood, body fluids, secretions, excretions except sweat, no intact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions includes hand hygiene, and the use of gloves, gown, mask, eye protection, or face shield to guard against blood borne pathogens if there is a reasonably anticipated exposure to blood or other potentially infectious materials. Most of these components are disposable to avoid carrying infectious materials from one person to another person. Therefore, OSHA requires the immediate removal and disposal of worker's PPE prior to leaving the work area where exposure to infectious material took place.

In accordance with VA Handbook 7176 Part 6, paragraph 3.603a., it is the medical center's responsibility to provide healthcare workers with PPE and training to promote personal safety. The medical center should also ensure that the employees wear the PPE.

The lack of an employee's knowledge in or use of, assigned PPE is clearly indicative that the employee has not retained or ever had the requisite understanding or skill to perform the function appropriate. The SPD leadership failed to comply with 29 CFR 1910.132(f)(2).

Additionally, in accordance with Federal regulations, The G.V. (Sonny) Montgomery Veterans Medical Center is required to:

- 1) Provide each individual who is required to use PPE with training per 29 Code of Federal Regulation(CFR) 1910.132(f)(1).
- 2) Provide PPE training that included the following elements, per 29 CFR 1910.132(f)(1)(i)-(iv):
  - a. When PPE is necessary
  - b. What PPE is necessary
  - c. How to properly don; put on, doff; remove, adjust, and wear PPE
  - d. The limitations of the PPE
  - e. Proper care, maintenance, useful life and disposal of the PPE
- 3) Have the SPD staff demonstrate an understanding of training and the ability to use PPE properly before being allowed to perform work requiring the use of PPE as per 29 CFR 1910.132(f)(2).
- 4) Ensure that individuals were retrained when there was reason to believe that they did not have the understanding or skills to use PPE properly per 29 CFR 1910.132(f)(3).
- 5) Have written certification for each SPD staff member who has received PPE training that includes the following:
  - a. Certification that employees received and understood PPE training in accordance to 29 CFR 1910.132(f)(4).
  - b. The training certification must include the name of the employee(s) trained,
  - c. The date of training, and the subject of the certification (i.e., a statement identifying the document as a certification of training in the use of PPE.

Based on the mere act of the Team conducting an in-service; training session, it falls short in meeting all the requirements set forth the Federal code. Also, in accordance with VHA Directive 2009-031, Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements, the Nurse Executive is responsible for the day-to-day supervision of SPD operations and ensures the Chief of SPD, or equivalent, implements the provisions as follows:

1. The Chief of SPD, or equivalent is responsible for ensuring:
  - a. The facility's reprocessing of all RME is performed with high reliability according to current manufacturers' instruction wherever these processes are performed and regardless of who is performing them.
  - b. Any and all individuals charged with reprocessing duties are appropriately trained and competent in performing the assigned tasks, and when SOPs are changed all designated staff are retrained and competency is again established.
  - c. Personnel reprocessing RME must be continually evaluated to ensure that they are demonstrating proficiency in all reprocessing activities and meeting all critical elements in their performance standards relating to RME. Appropriate training must be done whenever new or different equipment is used; new critical elements related to reprocessing must be added to performance standards, as necessary.
  - d. Temporary personnel must not be permitted to reprocess RME until training has been completed and proficiency has been demonstrated. Specific processes and procedures are in place for any given RME.

VA policy states that officials authorized to recommend or to approve the selection of a person for a position are responsible for being familiar with and following the policies and principles contained in the policy. VA Handbook 5005, Part II, Chapter 2, Para. 3. Additionally, it states that priority in selection for assignment to a position must be given to persons with statutory entitlement and that selections for positions will be based on the objective evaluation of the candidates' total qualifications for the position. "Qualifications" means the combination of experience, training, education, skills, knowledge, abilities, personal characteristics, and merit factors deemed to be pertinent to successful performance.

The recommendation from the OSC Investigation File No. DI-09-3272 in October 2009 was that the Medical Facility must hire an experienced Chief and Assistant Chief of SPD and six full time employees (FTE). Rather than comply with this requirement, the Nurse Executive, Dr. Dorothy White-Taylor, detailed yet another inexperienced Nurse Manager, to assume the role of the SPD Chief, and selected the former receptionist from the Director's suite to be the Assistant SPD Chief in lieu of applicants with total qualifications for the position. The former Acting, SPD Chief Joan Simon was detailed into a non existent position as the Nurse Educator of SPD. All of whom lack the requisite knowledge and skill sets required to provide guidance and leadership in directing the SPD staff or the organization responsibly.

Numerous attempts had been made throughout the two (2) year internship at the facility to address and resolve the internal problems which continues to plague SPD. Their internal checks and balances are merely a consortium of contrived data and falsified competency assessments

used for the sole purpose of camouflaging noncompliance and incompetence within the organization.

In theory, it appears reasonable to have an investigative entity from within the same organization in which the malfeasance originated from, may on the surface, be the most efficient means to resolve these allegations however, the investigative responses falls short of substantive evidence to supporting or showing that a credible investigation actually occurred rather than an institutional cover up commenced by cloaking the scope and the depth of the wrongdoing. All orchestrated to shield management and senior leadership from accountability by inappropriately levying the blame on the shoulders of the employees. In a feeble attempt by the Team to trivialize and degenerate the twenty seven (27) + allegations by rewriting and marginalizing them into what was purported to be three (3) general allegations only serves to diminish the value and integrity of the investigative process. If the systems protect fosters a system of invincibility and serves to compromise the integrity and intent of the investigative process.

As confirmation of the gross misconduct and negligent, lack of guidance and direction by senior leadership comes to the forefront and is realized, so does the Team's reaction to trivialize and degenerate the allegations by rewriting and marginalizing the twenty seven(27) allegations into what was purported to be three (3) general allegations.

There are a myriad of violation of laws, rules, and regulation from which to choose. The OSC Investigation File No. DI-09-3272 in October 2009 indicated that the "Infectious Disease Program Office (IDPO) reviewed SPD in November 2008, and with the exception of those recommendations that require space consideration, all of the recommendations have been implemented". The IDPO review of SPD in November 2008 cited SPD for PPE being stored in the GI Decontamination room. On the Day 1 of the cite assessment, SPD was cited for "Employee not wearing the appropriate PPE in Decontamination (We would receive and OSHA citation for this, if they were here)". Yet, in 2010 and 2011, PPE noncompliance issues still exist.

In summary, PPE is one of the vital components of a system of safety controls and preventative measures used in healthcare facilities throughout the nation. Senior management should ensure a work environment that values worker, patient, and public safety exists. In turn, SPD staff needs to take responsibility to properly use PPE. Although SPD staff should demonstrate personal responsibility for donning PPE when needed, the legal responsibility for staff PPE usage and adherence falls to the G.V. (Sonny) Montgomery Veterans Medical Center's leadership. Managers should ensure that the staff members they supervise also make proper use of PPE. The explanations for noncompliance and the solutions to these issues need to focus beyond the individual and address the institutional issues that prevent, allow or even favor noncompliance. The key factors in promoting a culture of safety within the agency that are pertinent to PPE is to provide competent leadership with a commitment to role modeling for worker safety; emphasize staff education, training, and awareness; enforce PPE policies and use through systems of surveillance and feedback; clarification of workplace practices and procedures, and ethical behavior.

## Endoscope Script for SPD

1. Where are your SOP's
  - a. Answers SOPS are kept in a binder at the workstation were scopes are cleaned.
2. Where are your manufacturer's guidelines
  - b. Manufacturer's guidelines are kept in book with sops in decontamination area
3. Where are your competencies stored?
  - c. In individual scope books with sop, manufacturer's instruction and training record.
4. How many types of scopes do you have?
  - d. Number Of brands. (3) - Olympus, Storz , Stryker
  - e. Number of models (8)
  - f. Break down of scopes- Stryker Ureteroscope model U-500 (3 scopes), Olympus LF-2 tracheal Intubation Fiberscope (1), Storz Flexible ureteroscope model 11274AAU (1), Storz Flexible Ureteroscope model 11278 AU1 (1)Olympus BF Type XP60, Olympus BF Type MP60, Olympus BF Type P60, Olympus BF Type IT60
5. Who trained you to clean a scope?
  - g. My supervisor / trainer
6. How do you clean a scope.
  - h. All scopes are cleaned based on manufacturers guidelines.
7. How do you ensure a scope is clean?
  - i. All scopes transported from OR to decontamination area will be manually cleaned and sent to prep area for sterilization.
8. Who cleans the decontamination area?

The counter tops, conveyor belt, and sinks are cleaned at the beginning and end of shift with one part Clorox bleach and 9 parts water by SPD staff. Facility Management staff cleans the room
9. How do you clean brushes used on scope.

Brushes are disposable and only used once.

VA Central Office  
 Reusable Medical Equipment Site Visit  
**Thursday, October 22, 2009**  
 Neurology Conference Room, K-206  
*Ms. Watson, Dr. Kirchner, Dr. Taylor, Ms. Abney, Dr. Rozario*

8:30 - 9:00 a.m.	✓ Entrance Briefing and Site Overview	Advance Team 1: Cath Lab
9:00 - 9:45 a.m.	Tour of Cath Lab      Leadership Team Review of Training, Competency, Observation	Advance Team 2: Resp.
9:45 - 10:15 a.m.	✓ Tour of Respiratory      Leadership Team Review of Training, Competency, Observation	Advance Team 1: GU
10:15 - 10:30 a.m.	Break	
10:30 - 11:15 a.m.	✓ Tour of GU      Leadership Team Review of Training, Competency, Observation	Advance Team 2: ENT
11:15 - 12:00noon	Tour of ENT      Leadership Team Review of Training, Competency, Observation	Advance Team 1: SPD
12:00 - 12:45 p.m.	Lunch and Team Meeting	
12:45 - 1:30 p.m.	✓ Tour of SPD      Leadership Team Review of Training, Competency, Observation	Advance Team 2: GI
1:30 - 2:15 p.m.	Tour of GI      Leadership Team Review of Training, Competency, Observation	Advance Team 1: OR
2:15 - 3:00 p.m.	Tour of OR      Leadership Team Review of Training, Competency, Observation	Advance Team 2: Radiology
3:00 - 3:15 p.m.	Break	
3:15 - 4:00 p.m.	Tour of Radiology      Guide Team Review of Training, Competency, Observation	
4:00 - 4:15 p.m.	Interviews - Cath Lab RN-Jim Bridges MD-Walter Woody Tech-n/a Resident-n/a	
4:15 - 4:30 p.m.	Interviews - Respiratory RN-n/a MD-William Pinkston, Rajesh Bhagat Tech-Johnny Smith Resident-n/a	

2383  
 1383  
 5993 - *Phonetic*

Reusable Medical Equipment Site Visit  
Friday, October 23, 2009  
Neurology Conference Room, K-206

8:00 – 8:15 a.m.	Interviews – GU RN-Eileen Fisher, NP/Billie Herbert MD-Donald Sawyer Tech-Marcia Black Resident- Allen Haraway
8:15 – 8:30 a.m.	Interviews – ENT RN-n/a MD-Christine Franzese LPN-Florine Young Tech-Pam Banks Resident-Dr. William Barber
8:30 – 8:45 a.m.	Interviews – SPD RN-Joan Simon/Dr. Taylor MD-n/a Tech-Gloria Kelly, Stacy Peterson, Katherine Johnson Resident-n/a
8:45 – 9:00 a.m.	Interviews – GI RN-Billy Herbert MD-David Snyder Tech-Beverly Lewis Resident-n/a
9:00 – 9:15 a.m.	Interviews – OR RN-Larry Lyons MD- Narayana Swamy Tech-Kenny Henry Resident-n/a
9:15 - 9:30 a.m.	Interviews – Radiology RN-n/a MD-Fred Rushton, Brighid McIntire Tech-Paul Lirette Resident-n/a
9:30 – 9:45 a.m.	Interviews – Dental RN-n/a MD-Joann Travis, Dale Vance Tech-Paul Eldridge (C.N.A) Resident-n/a
9:45 – 10:00 a.m.	Interviews – MICU RN-Valerie Snell MD-Paul Lowe Tech-n/a Resident-n/a

10:00 – 10:15 a.m.	Joan Simon
10:15 – 10:30 a.m.	Break
10:30 – 10:45 a.m.	Interviews – SICU RN-Tonya Galtney MD-Zurab Guruli Tech-n/a Resident-n/a
10:45 – 11:00 a.m.	Interviews – 2A RN-Melissa Brown MD-Charles Clericuzio Tech-n/a Resident-n/a LPN-Marvin Bolls Nursing Assistants-Tim Taylor, Velma Taylor
11:00 – 11:15 a.m.	Interviews – Vascular Procedure (Radiology) RN-Brenda Baker MD- Charles Clericuzio Tech-Paul Lirette Resident-n/a
11:15 – 11:30 a.m.	Interviews – Podiatry RN-Susan Fletcher NP Tech-n/a Resident-n/a LPN-Anna McElroy
11:30 – 11:45 a.m.	Interviews – EYE RN-n/a MD-Michael Palmer Tech-n/a Resident-n/a LPN-Keith Shannon
11:45 – 12:00	Charles Clericuzio
12:00 – 12:30 p.m.	Lunch
12:30 – 12:45 p.m.	Interviews – Foot clinic RN-Marie Bracey MD-n/a Tech-n/a Resident-n/a
12:45 – 1:00 p.m.	Interviews – Dermatology clinic NP-Jean Melton MD-n/a LPN-Debbie Joe Tech-n/a Resident-n/a

1:00 - 1:15 p.m.	Interviews – Emergency Department RN-Debbie Trussell MD-Boris Trifunovic Tech-n/a Resident-n/a
1:15 – 1:30 p.m.	Infection Control
1:30 – 1:45 p.m.	Break
1:45 – 3:00 p.m.	Meeting with Kent Kirchner, Ava Abney, Dorothy White-Taylor, Linda Watson, Shannon Novotny
3:00- 3:30 p.m.	Team Meeting
3:30 – 4:30 p.m.	Exit Briefing

**Advance Team 1:**

Marsha Arnold pgr: 1516  
Melody Link pgr: 1402  
Cara Roberson pgr 1560

**Advance Team 2:**

Lisa Morrison pgr: 1492  
Reesheda Rhymes pgr: 1001  
Marcy Joyner pgr: 1503

**Command Center:**

ext: 1219 or 7571 Zidia, Liz, or Sallie  
Text: 601-946-8243

**Scribes:**

Lelia Tucker pager: 1446  
Nikki Manning  
Ozie Nelson  
Cassandra Young

**Alternate Scribes:**

Barbara Baugh  
Shelah Teeters

**Facility Leadership**

Linda F. Watson  
Kent A. Kirchner  
Dorothy White-Taylor, Ph.D.

Nirmala Rozario  
Ava Abney

10/22/09 12:10pm

### Cath Lab Questions

Same Questions were asked in every area.

OSH-SOP-303 was asked about in all areas.

Asked Dr. K all question about program, procedures, where they were done prior to going there.

Do you have RME? What instruments do you use?

Do you double glove or wear heavier gloves when gross blood is present?

Do you wash gross blood off prior to sending down to SPD?

Does SPD clean all your instruments?

Do you ever have a shortage of equipment?

If instrument tray is missing something, what is the process for obtaining that instrument?

Asked if PIR is written when an instrument is not on the tray or appears dirty?

How do you handle sharps?

How are supplies brought up? Is there expiration date? Who checks and rotates the stock? Is anything in Peel Packs? Are they always sealed with exp. date and initials.

How is reprocessing done? Must be done every 5 days or before use.

Who validates the process for Supervisor responsible for Train the trainer in their area?

Wanted documentation that Jimmy had been trained by SPD Supervisor/Infection Control? How was he competent to do this training.

Continue to ask 2 or 3 times in every area. Do you run out of instruments and can't get them for a procedure?

How do we assure special equipment is cleaned, and how was a condom or a disposable cover used?

Addressed TEE process, do we have enough equipment and supplies to do 3 cases back to back?

Any equipment from outside that was brought in?

TEE – on last survey, finding on SOP.

What disinfectant solution used, how is it changed out, how do you document that it is in a safe time period to use.

Asked to walk through TEE reprocess. Walked through automated/ then talked through manual process.

How and who processed any type of dirty equipment, and got it to SPD?

Asked every place to see Biohazard Room and asked what they do with dirty equipment.

### Respiratory

All of the above questions were asked.

They validated negative pressure room, and asked to see logs for negative pressure testing. (Complete)

Asked about the number of reusable scopes they had and where were they processed?

Are all blades used for biopsies disposable?

Is everything single patient use?

Where are the scopes stored and how moved from place to place or up to unit?

Do they use lint free clothes?

Reprocessed every 5 days or before use?

How do you know serial number of each scope used?

Do they document number in the chart? Not required.

Sani-wipes. Why do they use them?

How do you check the flow sensors?

Requested cleaning process for flow sensor?

How do you track the bronchs QA? Process, privacy of information, and how long do we keep?

Watched actual demonstration of PFT and Flow Machine process.

Asked for manufacturer's instructions for both, cleaning procedure demonstrated, show how calibration is done, SOP. Compared.

Asked to demonstrate how took care of machines between patients, and type of germicidal wipes?

Asked how they change gloves, infection control process?

Records for approval for SOP for PFT system.

Negative pressure records for decontam room that is not monitored?

GU

Same questions. Answered well. No follow-up.

ENT

- 1) Lynn introduces a flexible endoscope that was broken at the stem and was sent down to surgery in that condition. There has not been an exact determination of how or where it was broken. Be careful to check all of your instruments before sending down.
- 2) There has been a disposable piece to the harmonic scalpel that has been sent back up with the instrument. One piece is black and one is green. They should be thrown away.
- 3) We are no longer sterilizing Dr. Yeager's micro-tip applicators or any other cotton tip applicator, (4x4's, sponges, etc.)
- 4) There are some new DePuy Mital anchors now with a new suture. A change from ethibond to ortho-cord.
- 5) There has been some issues come up with Kimberly Clark wrapping stock. There have been quite a few holes and tears in the paper.
- 6) Make sure when you pull Dr. Shorwood's cases, be sure to pull infinity and not intrepid.
- 7) There is still an ongoing problem with the mislabeling of sets and instruments. Please make sure the labeling is correct so the items can easily be found.
- 8) Make sure you keep up with all of your out-dates. Please sure to pull items seven days' ahead of time.
- 9) Joan states that everyone who is not in their proper PPE's in Decontam or prep will be written up. No Verbal warnings!
- 10) Catherine asks that all early personnel check the gas sterilizer to insure proper working order. Unload when ready - don't let the load sit in the sterilizer or open the door to get something out and to close the door. Just one spare test is needed.
- 11) All techs are responsible for their own areas. Please keep them neat.
- 12) Please adhere to proper break times and lunch times. Please don't

\* of time and conduct yourselves accordingly. Please don't bring newspapers or slouch around with feet on the wall. Be the professional you are.

13) When you leave the station, make sure you have proper approval

⑭ Maurice brings up violence in the work place. He states that if anyone takes offense to him, he will take it to the highest limit he can. Joe also brings up that Maurice's behavior was intolerable which he had no intentions of correcting. Joe plans on taking his case to the proper authorities. Maurice is responsible for the radio being gone two (2) different times.

- 1) The (1) of the pentax anesthesia bronchoscope is missing. Please try to locate it wherever it may be. There is a possibility it left the department going to pulmonary services, bio-med etc.
- 2) Decotam had an issue with blood being on a total hip retractor. Richard says they try to clean it as much as they can, but it really wasn't on them.
- 3) Surgery has been having a problem with opening the peel packs. There needs to be a little room between the end and the heat seal.
- 4) Decotam doesn't necessarily have to pull all the parts off of the instruments to clean them. They say, however, blood ~~has~~ indeed got into the middle of the screws and such.
- 5) There have been some call-ins in Decotam and everyone must rotate to cover the vacancy. No complaining, please!
- 6) Please try to control all of your walking. Stay in department.
- 7) Please try to tone down the loudness in the prep room. Quiet please!
- 8) No cameras are to go in trays. Peel pack them separately.
- 9) There are some new instruments that have come in. Jakes and hemostats as well as new self retaining retractors.
- 10) Phillip is re-arranging the Ortho row. Please locate where items are.
- 11) Dr. Kim is using the Kerlinger facial set for a drill bit. Drill bits are being ordered for him.
- 12) The new wrappers are to be used for gas or steam only. They will not work in the Sterrad machine.
- 13) Cat talked with Joan about the head sets and the radio. Head sets cannot be used because people are singing out loud and bothering people.
- 14) There are no other issues - meeting adjourned circa 1355 Thanks to all!

SPD Departmental Meeting Thursday, 10-1-09 1:

- 1) Please put supplies back on the shelf after they come back from surgery.
- \* 2) Cysto instruments must be pulled out of the scope so that they can properly be cleaned. If they are left in the scope, the case will be contaminated.
- 3) There are two (2) pistol grips that will go on both total hip sets.
- \* 4) All laparoscopic instrumentation must be disconnected to be properly cleaned.
- \* 5) Phillip has been re-arranging the shelves, so please go on and familiarize yourselves with the new placements.
- \* 6) There will be some new instrumentation coming in, so please ask if you don't know where they go.
- \* 7) Please pull the attachments of the drills off before you clean them.
- 8) Please write down five areas where you excel in and give to Jan for your evaluations.
- 9) Be on the look out for new RME and SOPs.

SPD Departmental Meeting Thursday, 10-1-09 13

- 1) Please put supplies back on the shelf after they come back from surgery.
- \* 2) Cysto instruments must be pulled out of the scope so that they can properly be cleaned. If they are left in the scope, the case will be contaminated.
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- 8) Please write down five areas where you excel in and give to Jan for your evaluations.
- 9) Be on the Look out for New RME and SOPs

SPD Assessment  
Bobby Osburn  
11/12/-14/08

2012 FEB 23 PM 2:54

Day 1:

- Wooden bulletin board in distribution area - unacceptable
- Sealed peel packs cannot be sent out from SPD Distribution area without being sterilized. Clinic instrument set was sterilized, and a peel pack was used to put blade with package. Users will think the package is sterilized, and will open on sterile field.
- Employee was not wearing the appropriate PPE in decontam. (We would receive an OSHA citation for this, if they were here).
- Asked for Dot and Joan's training records, organizational chart for each section, and SPD Deskguide
- Asked for official outline of training scheduled for staff (Neither side has one)
- Recommended both do training for both sides
- Purchasing agents work for VISN - May need to speak with Cynthia Due and see what is her authority over SPD from VISN level?
- There is no dedicated SPD purchasing agent
- No set process for ordering supplies used by both sides.
- OR Surgeons sometimes order directly through A&MM. Is our process of Commodity Standards Board to Resource Committee working?
- Wheelchairs and unattended O2 bottles were in hallway outside of SPD
- Distribution area (office supply by dumbwaiter) has paper storage, copier, desks, file cabinet (Need to move into office to make more room in distribution)
- PPE cart sitting at entrance to distribution to left of office space (Bad practice to put on PPE then walk down through distribution to sterile prep area)
- 4 SPD employees in cafeteria with caps, and scrubs. Bring bioburden back into Prep area. Employees should wear the appropriate attire for area.
- Equipment stored in supply area - Enormous amount of pumps on poles with plastic cover on top of pole, not over pump. Cover is being

put on in decontam. Should be put on after coming to Distribution side and plugged in during storage.

- Crash cart with bottom lock still unbroken had already been cleaned and was sitting ready for re-stocking. Staff didn't break lock and empty cart. Cart not air tight, and was cleaned in decontam. We broke bottom lock and bottom shelf was full of dust. Crash cart should be unloaded in break out area.
- Cannot leave code cart unattended in hallway
- Check inventory and discuss with CPR to reduce things that aren't used within 6 mths – year.
- Staff brought cart into area outside cart washer. Cart was hand cleaned in decontam. Cart washer broken, new one on dock waiting to be installed. Carts should be cleaned in cart washer, not decontam
- Large inventory of single toiletries, i.e., shaving cream, shampoo, soap, toothbrushes (Should these be bought out of SPD?)
- Asked for Stock on Hand < 3 days Report and Stock on Hand > 60 days Report
- Red dots on distribution item shelves mean Prime Vendor, blue dots – Miscellaneous.
- Vendor cart with implants – No list of inventory for consignment. Vendors can't bring anything in or out without going through SPD.
- Unsterile packs of sheets waiting to be sterilized on shelf.
- Large amount of custom packs for OR (Is this necessary?)
- Need SOPs for everything.

**SPD Distribution Side Unit Meeting WITH  
BOBBY OSBOURNE  
11/12/08**

1. Very positive with staff.
2. Five R's were discussed in meeting customer needs from SPD:
  - a. Right Product
  - b. Right Place
  - c. Right Time
  - d. Right Condition
  - e. Ready to use
3. SPD is the backbone of patient outcome unless there are no supplies.

4. SPD patient care services fall under infectious disease in CO.
5. Our SPD has two divisions:
  - a. Prep/Decontamination
  - b. Distribution
6. There are three answers that SPD staff should never give:
  - a. "I don't know."
  - b. "We have always done it that way."
  - c. "That's what they told me."-----Who are they?
7. When things are not taken care of the right way the two people that can be harmed are:
  - a. Patient
  - b. Employee
8. Issue of concern:
  - a. A code cart had been decontaminated but he found the bottom drawer still had a seal. When the seal was broken, contaminated supplies were in the drawer.
  - b. He said that all code carts should have two stickers:
    - i. One for the first date of supplies to expire.
    - ii. Second for the expiration date of the date of the first medication to expire.
  - c. All items in a code cart or any specialty cart should have at least a six-month shelf life.
9. Users do not care what the supply level is but want the supplies there when needed.
10. When the question of too little space was raised, he said that we had plenty of space. It was not being utilized well.
11. There should always be a three-day supply of secondary stock and seven day supply in the area.
12. Some things we have a six month supply of and some things we have less than one day supply.
13. He never wants to see an empty shelf. Never wants to hear "it is on back order." "It will be here tomorrow."
14. He wants a list on Friday of the things that we are routinely out of stock.
15. Emphasis was made on the fact that everything must be logged in and out to track stock. If levels are set correctly, we can't auto generate. Don't have to count the shelf every day.
16. Never assume anything, be a team and remember that the team is as weak as its weakest link.

17. Weakest point is the window. Get the name, title and location of people that have to go to the window for supplies. Find out why they have to come down for supplies.
  18. Issue: non-sterile items being packaged in sterile packaging. It is a patient safety risk for infection because the provider assumes the product is sterile. All sterile products must have an indicator tape on the packages that show they are sterile.
- Met with Chief, Surgical Service:
    - Went well. Main focus is from Patient Safety standpoint.
  - Short meeting with OR Head Nurse (meet again tomorrow)
    - SPD staff need to have orientation in OR
  - A&MM person (George Jeffcoat sometimes changes things in inventory for SPD) Speak to Joe Vaughn
  - Cart to transport supplies to isolation carts did not have impervious cover

SPD Assessment  
Bobby Osburn  
11/12/-14/08

Day 2:

- Inventory needs correction (What's ordered/Received don't match, units of receipt wrong in primary don't match invoice)
- Disaster Cart in SPD should be hard-sided & checked on schedule w/ least expiration date on outside
- Decrease # of people with access to change inventory in computer
- Drop money should not be used to buy primary vendor supplies (we lose money)
- 90% of all order from SPD are Emergency orders
- Using self-seal peel packs in Sterrad (not allowed)
- Challenge package for all 3 sterilizers were incorrect (Need to be in largest package in sterilizer)
- Need to order test pack from Sterrad and use silicone instrument pads
- ETO we are using has not been approved (Get rid of)
- At what level does the ETO sensor alarm?
- Holes in wall of ETO room into prep
- Steam sterilizer drains need to be cleaned daily
- We use "Smart Pac" challenge in steam sterilizer, but not at optimal time of 3.5 min. (We do 4 min.)
- Be more specific when labeling contents of sterilizer pack on envelope in case of a recall (Not Eye x 3) Also must be readable
- Indicator tape expired in Sterile Prep
- Storage in Sterile Prep must be enclosed
- Need inventory of all instruments (not on shelves in Sterile Prep)
- Brushes – All were badly used
- Biological Implants – 48 hours (Release) —
- Cannot re-use (sterilize) linen with old tape ~
- Indicator tape cannot be used on anything but sterilizing
- Open pack of 4x4s in prep on table —
- Scissor sharpness need to be checked everytime on gauze
- **No positive pressure from Prep to Decontamination** ~
- Humidifier chart in Prep not changed for 2 wks. ~

- Plastic locks used on case carts (need metal tamper proof with indicator) Can be opened and no one would know
- Count sheet for case carts not being double-checked and need to be 100% complete
- Incomplete sets are not documented on the outside
- Gauze should not be put in trays for sterilization (Only radiopaque gauze)
- Don't use white paper in instrument trays instead of radiopaque towels
- Frazier suction needs to be together in tray but not locked
- If something looks like rust on an instrument and comes off when wiped IT IS AN ISSUE
- Rubber bands being used on end of forcep racks
- Implant – Anything that has the potential to be placed in the body and covered with tissue
- Found dust covers sealed with scotch tape
- Need to expand case cart area
- LINE needs to be RED for division of Distribution to Case Cart
- Need procedures for all SPD tasks
- Sterile/Prep and Decontam need to be cross-trained
- ETO - Must monitor every bag at this time
- Using wrong size self-seal dust covers over peel packs
- Have to have sterilizer instructions on everything you sterilize
- Staff not wearing all PPE in Decontam
- Proper dress attire inside and outside of SPD needs to be enforced

#### Cath Lab

- Need documentation Log for TEE Probe
- Transport in hard sided container
- Need vendor checklist of implants (Checked everytime they come in)

#### Respiratory

- Corrugated boxes in bronch room
- Need enclosed cabinet for supplies
- PPE for decontam should be put on in bronch lab
- Gowns in bronch decontam, not impervious
- Using rapicide (O.K.) No negative pressure in room with washer/disinfector

- Better to sterilize bronchoscopes in SPD
- Mass flow sensor for PFT's

#### Dental Clinic

- Decontam in supply room
- Hand pieces lock up if not done in gravity sterilizer
- Wood cabinets in Decontam
- Many instruments in peel packs without exp. stickers, open pkgs. And holes from sharp instruments (tip protectors) caps, water stains on bottom of peel pack

#### Decontam:

- Need all sizes blue gloves
- Found kitchen aprons/regular gloves
- Pumps decontam with covers put on in decontam
- Wooden desk needs to go
- Should push clean carts through cart washer door – Prep should get out the other side
- Steaming carts – Do you need ear protection (FMS check level)
- Traumatic towel clips open coming from OR
- Eye wash blocked by garbage can

#### Day 3

- Print off SPD Self Assessment from website with references to 7176
- Need Item manager in SPD
- Should see no empty shelves
- No one in another building should be making changes in inventory

#### GI Clinic

- Corrugated boxes in clean room
- Make sure scope ID can be tracked to patient
- Need to sign Olympus tapes with full name and date
- PPE stored in Decontam room
- May need a pass through window from clean to dirty
- No Negative Pressure in decontam room

- Length of time scopes are stored between use should be tracked ( 5 Days- Who says)
- Scopes touching bottom of scope cabinet
- Guide wires used for esophageal dilators not sterilized
- Esophageal dilators (chance of tearing tissue, should be sterilized)  
Need manufacturer instructions
- Forceps being used in scope room to pick up tissue then disinfected in Olympus

#### GU

- Pegboard in cabinet needs to come out
- Cidex OPA was in GU – Usually not used in GU (contact with bladder tumor)
- Using single use scope cleaning brush on same scope all day long on same patient
- Cidex OPA can't be used on probes
- Cystoscopes should be processed in SPD
- Needle gun needs to be steam sterilized
- Transducer probe covers should be purchased sterile
- Maybe disposable guns with needles

Sinks in supply closets need to have water cut off

#### OR

- Remove Sterris from OR
- Sterile core area should not have covers
- Omnicells used for storage not being cleaned properly (Should use wire shelves)
- Too much inventory on Emergency Cart
- Room L-17 Equipment storage – dirty, corrugated boxes, flammable cabinet not vented, plastic stuck in lock on door to keep from locking

#### Anesthesia

- Decontam in clean supply room
- Corrugated boxes
- Use disposable blades/ manufacturer cleaning instructions/ fiberoptic blade and handle
- Tubing on Anesthesia machine – should be sterilized

## ENT

- Expired gas tape
- Corrugated boxes
- Peel packs used as storage
- Documentation not complete
- Expired supplies in ENT Nurse Cabinet
- Sterilized pkg., not exp. date
- Rubber bands around sterilized items
- Box of endosheaths – Says they don't use, but think going to reprocess after use

## EYE

- No tonometer processing – Use disposable, no decontamination

## Radiology

- Transvaginal Probe –
- Germicidal foam and let it dry
- Sterile towels run twice – Probably expired

## 2A Ward Supply

- Overstocked
- Dirty bin sitting on top of wire cart full of supplies (posey splints, sandbags, etc.)

## 4CN

- Supply room looks better, but still overstocked

## Hemodialysis

- Cidex cont full of towel clips, scissors
- Cidex not dated

**Kelley, Gloria A. (VHAJAC)**

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Wednesday, July 28, 2010 4:35 PM  
**To:** Watson, Linda F. (SES) (VHAJAC); White-Taylor, Dorothy M. (VHAJAC)  
**Cc:** Simon, Joan A. (VHAJAC); Abney, Ava C. (VHAJAC); Lack, Regina C (VHAJAC)  
**Subject:** RE: Contamination

Mrs. Watson,

*He is the son of the Deputy Associate Director, Patient Care Services*

There were Ruby Lawson, John Brown, Troy Dampier, (Gerald Cook), and an unknown female contractor, all at the sinks at various intervals on yesterday, Tuesday, July 27, 2010, Monday, July 26, 2010 in violation of policy and procedure as well as previous week, Monday, July 19 – Thursday July 22, Stacy Brown along with the above listed personnel were non-compliant with the exception of when the inspector from Biloxi visited the area.

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**From:** Watson, Linda F. (SES) (VHAJAC)  
**Sent:** Wednesday, July 28, 2010 3:50 PM  
**To:** Kelley, Gloria A. (VHAJAC); White-Taylor, Dorothy M. (VHAJAC)  
**Cc:** Simon, Joan A. (VHAJAC); Abney, Ava C. (VHAJAC); Lack, Regina C (VHAJAC)  
**Subject:** RE: Contamination

Thank you for raising this.  
Who is violating the procedure and on which dates

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Wednesday, July 28, 2010 3:14 PM  
**To:** White-Taylor, Dorothy M. (VHAJAC); Watson, Linda F. (SES) (VHAJAC)  
**Cc:** Simon, Joan A. (VHAJAC)  
**Subject:** Contamination

Hello Dr. Taylor,

I've made numerous attempts of bringing this egregious practice to the attention of the (Acting) SPD Chief, Joan Simon however, she has repeatedly told me that the "Front Office" is aware of this situation but refuses to take any action. Whether this is true or not, the fact is that Decontamination personnel are jeopardizing the health, safety, and well being of self, co-workers, customers, and patients at this facility by not wearing any facial shields, goggles, or masks while inside the Decontamination area. Some are putting on PPE once inside Decontamination, and are wearing outer covering retrieved from within Decontamination and wearing it throughout the facility. However, whenever there is an inspection, the full PPE is donned in its entirety. This selective blatant disregard for following facility, VHA 7176, OSHA TJC, etc. policy and guidelines, places everyone at the facility in grave danger and greater risk of becoming infected with contaminants transported throughout the facility by Decontamination personnel. This is not a game, but real life, and I would like to have a reasonable expectation of coming work and not being subjected in infection via cross-contamination from and employee.

I take exception to this reckless and irresponsible behavior of the Acting Chief's unwillingness to take the appropriate immediate action to end these egregious acts of the Decontamination area employees and even more so of the cavalier attitude of the Acting SPD Chief's willingness to skirt the issue and redirect responsibility to the "Front Office".

Dr. Taylor, below is an excerpt from 7176.

**4. 304 DECONTAMINATION AREA**

a. This area is used for reducing the bioburden of reusable medical supplies, instruments, or equipment. Utilizing the universal/standard precaution concept that all items received are considered contaminated, specific attire is required to protect the employee's personal protective equipment. Special attire will consist of the following:

- (1) Scrub suits (not considered PPE).
- (2) Approved head and hair covering.
- (3) Face shields (cover from ear lobe to ear lobe and below the chin). If a face shield is not utilized, safety glasses/goggles will be worn with a surgical face mask.
- (4) Long cuffed rubber/vinyl decontamination gloves (not surgical gloves).
- (5) Impervious gown (this should be either disposable or reusable; long sleeved; fluid- impervious from elbows to cuff and from neck to bottom of gown; and length will be below the knee).
- (6) Impervious shoe covers (not paper shoe covers).
- (7) Jewelry is limited to wedding rings and post earrings.
- (8) False fingernails will not be permitted.

(Note: The above attire will not be stored in the decontamination room; it will be put on before entering the decontamination area and will be removed before leaving the decontamination area. No one is to be in decontamination without wearing the proper attire).

PPE worn while working in the decontamination area will not be worn in any other area of SPD or the medical center.

Your consideration in this matter is greatly appreciated,

*Gloria A. Kelley*

Gloria A. Kelley, CRMST

Chief, SPD Intern

G.V. (Sonny) Montgomery VA Medical Center

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Jackson, MS 39216-5199

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IMPORTANT NOTICE: This communication, including any attachments, contains information that may be confidential. It is intended solely for the individual or entity to whom it is addressed. If you are not the intended recipient, please notify me at [gloria.kelley@va.gov](mailto:gloria.kelley@va.gov) and delete this message. You are hereby notified that any disclosure, copying, or distribution of this message is strictly prohibited. Nothing in this e-mail, including any attachment, is intended to be a legally binding signature.

## **Kelley, Gloria A. (VHAJAC)**

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, October 20, 2009 5:07 PM  
**To:** Johnson, Catherine (VHAJAC); Harris, Martha L. (VHAJAC)  
**Subject:** FW: URGENT – Review of Reusable Medical Equipment (RME) Site Visit by Medical Inspector's Office  
**Attachments:** Feedback - OMI Visits.pdf, VHA Dir 2009-004.pdf, VHA Dir 2009-031.pdf  
**Importance:** High

Ladies,

Here is the information regarding the upcoming IG inspection per our earlier conversation.

Gloria

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**From:** Lack, Regina C (VHAJAC)  
**Sent:** Tuesday, October 20, 2009 12:24 PM  
**To:** Kirchner, Kent A. (VHAJAC); Novotny, Shannon C. (VHAJAC); Rozario, Nirmala (VHAJAC); Watson, Linda F. (SES) (VHAJAC); White-Taylor, Dorothy M. (VHAJAC); Abney, Ava C. (VHAJAC); Arnold, Marsha C (VHAJAC); Spruill, Emily E. (VHAJAC); Webb, Risa M. (VHAJAC); Geraci, Stephen (VHAJAC); Anderson, Leon (VHAJAC); Clericuzio, Charles P. (VHAJAC); Simon, Joan A. (VHAJAC); Wainwright, Don (VHAJAC); Babineaux, Katie A. (VHAJAC); Banks, Zarata (VHAJAC); Baylis, Lasha V. (VHAJAC); Bridges, Jimmy C. (VHAJAC); Bruce, Lisa B. (VHAJAC); Caston, Brandy R. (VHAJAC); Clericuzio, Charles P. (VHAJAC); Collins, Licinda (VHAJAC); Cox, Richard G. (VHAJAC); Easterling, Jimmie E. (VHAJAC); Eldridge, Paula (VHAJAC); Franzese, Christine (VHAJAC); Herbert, Billie S (VHAJAC); Kelley, Gloria A. (VHAJAC); Kirsh, Leola R. (VHAJAC); Lamboi, Marilyn B (VHAJAC); Low, Paul (VHAJAC); Lyons, Larry J. (VHAJAC); McFrederick, Pamela C (VHAJAC); Peters, Sherry D (VHAJAC); Readus, Latoya (VHAJAC); Robbins, Julie L (VHAJAC); Sherwood, Charles G. (VHAJAC); Smith, Johnny Lee (VHAJAC); Snell, Valerie E (VHAJAC); Vaughn, Joseph P (VHAJAC)  
**Cc:** Rucker-White, Thantween S. (VHAJAC); Dodd, Mary A. (VHAJAC); Galbreath, Sallie C. (VHAJAC); Colvin, Merida (VHAJAC); Houston, Carolyn M. (VHAJAC); Robbins, Julie L (VHAJAC); McFrederick, Pamela C (VHAJAC); Bruce, Lisa B. (VHAJAC); Johnson-Hood, LaToya T. (VHAJAC); Burroughs, Kristi (VHAJAC); Weeks, Carol B. (VHAJAC)  
**Subject:** URGENT -- Review of Reusable Medical Equipment (RME) Site Visit by Medical Inspector's Office  
**Importance:** High

FROM: Center Director (00)

TO: Pentad  
RME Group

- 1. Beginning on Thursday October 22, at 8 a.m. through Friday, October 23, 2009, the Medical Inspector Office will conduct an extensive review of RME that will include areas that use RME and areas that clean as well as use RME. They will specifically look at and review:**
  - how the areas that use RME ensure that equipment is cleaned prior to use, and if not, how this is communicated to SPD and leadership, and what actions were taken to ensure it does not happen again.
  - SOPs, competencies, and training records.
  - Documented staff meeting minutes that discuss RME.They may want to observe the actual use or cleaning of equipment.
- 2. Please provide excerpts of RME discussion from staff meeting minutes to the Director's Office by COB today. Also, the following Governance information must to the Director's Office by COB today as well:**

- QEB Minutes that reference SPD – Dr. White-Taylor, Thantween Rucker-White, Mary Dodd
- RME Oversight Committee – Ava Abney, Marsha Arnold, Sallie Galbreath
- Infection Control minutes that reference SPD – Mimi Spruill
- CEB minutes that reference SPD – Julie Robbins, Mec Colvin
- Chief of Staff Meetings – Dr. Kirchner, Julie Robbins, Mec Colvin
- VISN Site Visit Plan – Ava Abney, Marsha Arnold, Sallie Galbreath
- Osborn Spreadsheet (updated) – Ava Abney, Marsha Arnold, Sallie Galbreath
- Scope Deep Dives – Ava Abney, Marsha Arnold, Sallie Galbreath
- OIG site visit dates – Ava Abney, Marsha Arnold, Sallie Galbreath
- Network Director scope review visit – Ava Abney, Marsha Arnold, Sallie Galbreath
- Responses to VISN Action Items for RME – Carol Weeks, Lisa Bruce

3. We have been asked to arrange tours for all areas listed below, and set up 15 minute interviews for staff (MDs, RNs, techs, residents, NAs, etc.) in each area. Please identify the staff that work in those areas that use RME so we can complete the agenda for the team. This information should be sent to Ms. Lack by 1 p.m. today.

Areas that receive sterile RME from SPD:

Dental  
 MICU  
 SICU  
 2A  
 Vascular Procedure Clinic  
 Podiatry  
 ENT  
 Foot Clinic  
 Dermatology

Areas that process and use RME:

Operating Room  
 Respiratory  
 Cath Lab  
 ENT  
 GU  
 GI  
 Eye Clinic  
 Radiology (Ultrasound)

4. Attached is a feedback report regarding a Medical Inspector site visit. Please review with your staff. Make sure you know the answer to questions that pertain to your area. Provide confirmation to the Director's Office that you and your staff have reviewed and are prepared to answer questions consistent with VA and medical center policies and directives. Also provide a copy of your program area responses to these questions by 9 a.m. tomorrow. Negative responses are required.
5. Please review, ensure you are familiar with the requirements of, and have implemented appropriate actions required by the attached directives:
- VHA Directive 2009-004, dated 02/09/09, Use & Reprocessing of RME in VHA Facilities
  - VHA Directive 2009-031, dated 06/26/09, Improving Safety in the use of RME Through Standardization of Organizational Structure & Reprocessing Requirements

/s/  
Linda F. Watson

**U. S. Office of Special Counsel  
1730 M. Street, N.W. Suite 300  
Washington, DC 20036-4505**

**Report of Investigation to the U.S. Office of Special Counsel  
OSC File Number DI-09-3272**

The Secretary of Veterans Affairs asked the Veterans Health Administration (VHA) to review a complaint lodged with the Office of Special Counsel (OSC) by an anonymous employee at the G.V. Sonny Montgomery Veteran Affairs Medical Center, Jackson, Mississippi (hereafter the Medical Center). The complainant raised allegations concerning the health and safety of patients and employees at the Medical Center. Specifically, the complainant alleges:

1. For 5 years, doctors and staff at the Medical Center did not follow Occupational Safety and Health (OSH) Standard Operating Procedures (SOP) 3003 when they failed to sterilize medical instruments. Instruments used on patients for procedures, including minor surgery, are merely wiped with a Sani-Wipe and re-used on the next patient. Doctors and staff regularly exhaust their supplies of clean instruments before they are finished seeing patients, and choose to reuse instruments to see more patients.
2. In the Ear Nose and Throat (ENT) Clinic, nurses have been observed using trays of unsterilized instruments.
3. Staff received sterile instruments that actually had dried blood on them or sterile instruments not individually bagged to preserve sterilization.
4. The lack of sterile instruments has led to patients and staff being regularly exposed to infectious, viruses, and bacteria on a regular basis: Human Immunodeficiency Virus, hepatitis, methicillin-resistant Staphylococcus aureus, bacterial-fungal infections, and warts. Veterans have not been notified of their possible exposure or tested for any infection that may result from such exposure.
5. Although management official are aware of this continuing public health danger, they have taken no action to address the problem.

**Facility Profile**

The Medical Center is a tertiary care facility classified as a Clinical Referral Level 1 teaching hospital with several affiliations, including, the University of Mississippi School of Medicine. It oversees Community Based Outpatient Clinics (CBOCs) in Columbus, Hattiesburg, Meridian, Greenville, Kosciusko, Natchez, and Meadville, which serve, Mississippi counties of Attala, Carroll, Holmes, Leflore,

Montgomery, Sharkey, Humphreys, Sunflower, Washington, Covington, Forrest, Jefferson Davis, Jones, Lamar, Marion, Perry, Wayne, Adams, and Wilkinson, along with the Arkansas counties of Chicot and Desha. Comprehensive health care is provided through primary care, tertiary care, and long-term care in areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, geriatrics, and extended care. The Medical Center is a part of Veterans Integrated Service Network (VISN) 16, with facilities in Mississippi, Louisiana, Texas, Arkansas, and Oklahoma. The Medical Center is fully accredited by Joint Commission Accreditation Hospital Organization (the Joint Commission).

### **Methods for Conducting the Investigation**

The VHA team notified the Medical Center Director of the anonymous complaint and of its plans for an October 22-23, 2009, site visit. The Associate Director coordinated the visit and the investigators received full cooperation from the Medical Center staff as they conducted the visit. The investigative team consisted of the Director, Clinical Investigations, Office of the Medical Inspector, the Clinical/Quality Assurance Liaison for the Office of the Deputy Under Secretary for Health for Operations and Management, an Associate Director Nursing/Patient Services Care, and an Infection Prevention and Control Professional, Infectious Diseases Program Office, Supply Processing and Distribution Liaison.

After holding an entrance conference with Medical Center leadership, the team assessed and interviewed physicians, nurses, and technicians in the following areas: Cardiac Catheterization Laboratory, Respiratory/Bronchoscopy, Genitourinary, Gastrointestinal, Operating Room (OR), Medical and Surgical Intensive Care Units, Radiology/Vascular Procedure Suite, Ophthalmology, Orthopedics, Dental, Podiatry, Dermatology, Emergency Room, and Supply Processing and Distribution (SPD). Individual interviews were conducted with the previous Chief, SPD, Acting Chief, SPD, Acting Assistant Chief, SPD, SPD Supervisor, Patient Safety Officer, Chief, Quality Management, Infection Control Manager, MSRA Coordinator, Chief, Infectious Disease, Chief, Surgery, Associate Director, ENT Physician, Chief, Emergency Room, Chief of Staff and Chief, Nurse Executive. During the visit, the team reviewed the following documents:

- National Infectious Disease Program Office Site Visit Report November 2008
- Email from Medical Center staff
- Position Description Quality Manager/SPD
- Medical Equipment Purchases
- Patient medical records
- Infection Control Minutes
- Clinical Executive Board Minutes

At the conclusion of the site visit, the team held an exit conference with Medical Center leadership.

## **Background**

### **Supply Processing and Distribution (SPD)**

The Medical Center's SPD department, opened in 1991 under the direction of Acquisition & Material Management (A&MM), has two sections: supply/distribution and sterilization. Both appeared to have operated well initially. But SPD was staffed by lower pay grade personnel that were transferred from other locations -such as housekeeping, food service, laundry-and had no formal training in SPD. In 2000, the Chief of Surgery, received frequent complaints from surgical staff about incomplete instrument trays in the operating room, inadequate inventory control of medical supplies, and issues with soiled instruments. In January 2001, the Associate Director held meetings with the Chief of A&MM and Chief of SPD to formulate an action plan, which included an invitation to the Chief of SPD at the Veteran Affairs Medical Center, Little Rock, Arkansas, for a consultative visit. This visit resulted in recommendations to improve staffing, the stocking surgical supplies, and the handling of surgical instruments.

Although the recommendations led to some improvement in SPD in 2001, the Surgical Chief continued to receive complaints of inadequate reusable medical equipment (RME), problems with inventory control and soiled instruments. In an effort to address these concerns, the Medical Center leadership put an operating room nurse in charge of SPD, and reorganized the SPD department. These measures appeared to be effective for a while, but in 2006, the complaints resurfaced. Leadership instituted a Healthcare Failure Mode & Effect Analysis (HFMEA), and implemented its recommendations. Later that year, an Office of Inspector General (OIG) Hotline Complaint 2006 03529-HL-0066 alleged lapses in safety and infection control, i.e., a) patient exposure to HIV/AIDS or hepatitis because of unsterile conditions in surgery and nursing, b) instruments not being sterilized prior to use in surgery, c) instruments not sterilized between cases in surgery, d) operating rooms not appropriately cleaned between cases, and f) an attempt by leadership to cover up poor practices.

VISN 16 tasked a team from the Veteran Affairs Medical Center Shreveport, Louisiana to investigate this complaint but the team could not substantiate the allegations; it did, however, make consultative recommendations. On the basis of this team's report, the OIG closed the investigation. Later, Medical Center leadership hired a Perioperative Healthcare Consultant, who was there for a extended period of time, to review the SPD Program, including, staffing, training, competencies, work flow, inventory control, instrument tracking/trays, and

reprocessing of reusable medical equipment. Following this assessment, a post-anesthesia recovery room nurse was put in charge of SPD as acting Chief; an intern in training is assistant Chief, and this is the current leadership in SPD. Neither of these individuals had prior SPD training. In addition, five staff from SPD retired in 2006, which left the department short of staff.

Over the following year, several actions were taken to address the ongoing concerns about SPD. The VISN leadership met with the Chief of Surgery in 2007 to implement formation of an Operating Room Committee that oversaw SPD and tracked SPD-related issues. Under this oversight, three full time equivalents were approved for the decontamination area, a survey of end users was conducted, and surgical clinicians were included in the purchases of supplies and equipment. Since 2008, the Medical Center has also purchased more instruments with the RME funding from the VISN/VA Central Office. The operating room just recently reached the point where they had enough back up instruments, including for urology and that flash sterilization was dramatically decreased. In addition, over \$100,000 had been spent on Podiatry equipment and instruments.

The Infectious Disease Program Office (IDPO) reviewed SPD in November 2008, and with the exception of those recommendations that require space consideration, all of the recommendations have been implemented.

Over the last year, Medical Center leadership has acted to improve SPD by recruiting a Chief and Assistant Chief, six SPD staff positions, establishing a quality manager position to oversee SPD, and developing policies for critical, semi-critical, and non-critical reusable medical equipment. Leadership also developed a RME Quality Oversight Committee within SPD, review instrument incidences in the OR Committee, and instituted RME Leadership rounds.

When oversight for the components of Supply Processing and Distribution (SPD) that pertained to processing of reusable medical equipment and storage of sterile supplies was moved from Acquisition and Materiel Management under VHA to the Infectious Diseases Program under Patient Care Services (PCS) in VHA, SPD materials were moved from the Acquisition and Materiel Management website and temporarily housed on the website of VHA's Office of Occupational Safety and Health (OSH). At that time PCS was not able to accommodate the need for an SPD website, Acquisition and Materiel Management strongly requested that the SPD information be removed from their website, and OSH permitted the temporary housing of the SPD material to allow for continued access to such material by VHA Medical Centers. When SPD was under Acquisition and Materiel Management, a SPD Advisory Group with members from the Medical Centers was established to generate SPD Standard Operating Procedures (SOPs) to be used as a guide for facilities to develop their own SOPs on a variety of topics. Prior to the listing of these SOPs on the website, there is a note that states: "These SOPs are developed as a guide for the starting point of your local SOPs they must be customized to detail the procedure locally. Local procedures must be signed

and approved at facility. Also at no time will a SOP be written or followed to violate policy.” Therefore, the SOP numbered 3003 and titled Instrument Care and Handling is only a guide and not a requirement. The guide can be used by facilities as a starting point and customized as applicable at the local level. The VHA has some national policies that pertain to processing of RME, as well as local policies that are approved by leadership and addresses principles as outlined in SOP 3003. The Medical Center has its policies and SOPs that are facility/equipment specific.

## **Site Visit Findings**

### **Cardiac Catheterization Laboratory (Cath Lab)**

The Cath Lab uses sterile instruments on a daily basis. An examination of instruments from the cath lab's storage area, revealed no outdated or dirty instruments. The technicians, nurses, physician, and resident interviewed had no concerns about the instruments they receive from SPD.

### **Ear Nose Throat (ENT)**

ENT uses and reprocesses their own scopes; however, they rely on SPD for sterile instruments, reporting any shortcomings to the Chief of Surgery and the Patient Safety Manager. In February of this year, ENT reported a lack of properly sterilized and peel packed instruments, a lack of properly sterilized instruments for an entire week, requiring them use disposable instruments and to scramble to get needed instruments from other sources. They estimated that 10 – 12 incidents over the last year.

On August 13, 2009, in operating room Suite 2, a rigid metal lumen suction tube was found to have debris in it, causing contamination of the sterile field. The tube was removed and the new sterile field was established with new equipment. A second tray was readily available, so there was no delay in surgery. In addition, the instrument tray with the dirty tube was mislabeled “OR. Ridig Esophagoscopy Ridig Scope;” it should have read “Adult Esophagoscopy Set.” ENT has also received sterile OR instrument trays with the wrong expiration dates as well as missing instruments.

The nurses and physician in ENT deny using trays of unsterile instruments. Due to their recent experience they are vigilant about examining instruments prior to use. No one interviewed could verify that they observed nurses in ENT using unsterilized instruments. It should be noted that ENT also uses equipment that comes in touch with the skin that does not require sterilization.

Because SPD staff are required to sign the instrument trays they prepare, the individual who prepared the sterile instrument trays for OR Suite 2 has been

identified as Bessie Spriggins and nursing leadership is proposing disciplinary action in the form of a 14 day suspension.

### **Respiratory**

The respiratory department does not use instruments requiring sterilization by SPD.

### **Genitourinary (GU)**

GU has one cystoscope which is reprocessed within their department while biopsies are being done. The staff was proud that the scope had not broken down: they had no contingency plans if it did break down. GU has purchased 10 additional cystoscopes, which arrived during this site visit. They do not use sterile instruments from SPD.

### **Gastrointestinal (GI)**

The gastrointestinal section does not use instruments requiring sterilization by SPD.

### **Operating Room-Post Anesthesia Care Unit (OR-PACU)**

The OR has issues with dirty instruments about once a month. The nurses there are observant enough to notice such defects before operations are performed, submitting patient incident reports to nursing for each instance. SPD is also contacted directly to discuss this issue and the OR Committee addresses all incidents of dirty instruments. The OR sometimes receives sterile instrument in packs with no expiration date, the incorrect expiration date, or broken wrappers. Incomplete instrument sets have also been an issued but this has improved. The nurse manager indicated that staff normally double glove, so the susceptibility to infections is minimal. Flash sterilization is rarely required or used. The PACU uses disposable instruments/equipment. There was also and incidents where a glidescope blade and a camera were melted during reprocessing

### **Medical and Surgical Intensive Care Units**

The intensive care units receive and use instruments sterilized by SPD. The staff interviewed, including a physician, residents, and nurses, indicated that they had no issues with instruments processed by SPD.

## **Radiology/Vascular Procedure Suite**

Radiology uses relatively few instruments from SPD, but will need to develop a standard operating procedure for pre-cleaning the ones they use. The Ultrasound Vaginal Probe is reprocessed in the examination room after patients have been seen. If they had more room, separating the functions of examination and pre-cleaning would be ideal, but overall there were no complaints with general sterilization. The room lacks a timer and a sterilization logbook for start and stop times. They are getting both.

## **Ophthalmology**

This department has four full-time ophthalmologists, three residents, and no optometrists.

On occasions ophthalmology has received damaged equipment from SPD, and they cannot see the damage except under magnification. They would prefer to have one SPD technician handle their instruments. All tonometers are disposable. They do reprocessing of contact lenses in their department, tips for A and B scans, probes and diagnostic lenses. Gonio lenses are kept in wooden boxes that cannot be sterilized. They have portable timers that attach to their belts and all have good competencies. The physicians are signed off by SPD staff that they are competent to reprocess their equipment.

## **Radiation Therapy**

Radiation therapy uses a Zisper clamp which is pre-cleaned and sent to SPD: the staff had no issues with the sterilization of the clamp by SPD.

## **Dental**

Dental uses many metal instruments sterilized by SPD. Staff there was very complimentary of the service and sterilization of their instruments. The dentist, the dental assistant, and the dental assistant supervisor all indicated that they would allow the use of instruments processed by SPD on themselves or their family.

## **Orthopedics**

Orthopedic clinic does not use instruments from SPD except for wire cutters which do not come into contact with patients. Orthopedics uses sterile instruments in the OR and does have concerns about the processing of drill bits.

## Podiatry

Two contract podiatrists have worked for the Medical Center one day a week; one from January 1993–June 2009 and the other February 1998–June 2009. The Medical Center hired a full time podiatrist in 2006 and a second one sometime later. In 2006, the Chief, Surgery received e-mails from the full-time podiatrist expressing concerns that instruments were not being sterilized, and were being wiped off between patients by the contract podiatrists. An investigation by the Chief of Surgery discovered that instrument trays for podiatry were sterilized, but contained an insufficient number of nail nippers, and these were being wiped off between patients in the clinics. This practice was immediately halted and additional instruments purchased. Later that year, the same podiatrist complained that dirty, rust-stained instruments were being sent to the clinic. The Infection Control Nurse cultured the instruments; they were negative for organism growth. The company representative determined that the stains were a build up of calcium. SPD now closely monitors podiatry instruments after sterilization.

Interviews with the podiatrists revealed that at one point things had improved, but problems with blood, and rust-stained instruments has recurred. The investigative team removed five instruments from the podiatry cabinet and found two with what appeared to be dirt/particles on them; all five of the instruments were stained.

The Medical Center has determined that the type and quality of the instruments purchased for podiatry may also contribute to this recurring problem. As instruments purchased for surgery are a higher grade of stainless steel than those in podiatry. In addition, somehow disposable instruments are sent to SPD and get reprocessed and are visibly discolored. Another contributing factor is possibly the well water supply. Recently the Medical Center built a water tower to reduce the mineral buildup on the instruments.

The team contacted the Medical Center following the site visit with some follow up questions: With regard to how long did the contract podiatrists wipe instruments between patients, the initial response was the entire time that they practiced at the Medical Center. On October 27, 2009, the team received the following response after the Medical Center contacted the contract podiatrists in their private practice: "is that prior to 2006, podiatry nippers that had blood products on them were sent to SPD for sterilization. Those nippers that had no signs of blood products were wiped off and placed in a container of high level disinfectant (Cidex) for 20 minutes to kill organisms." This is inconsistent with what we were told during the site visit and as described in the OSC complaint. The team did not interview the contract podiatrists because they no longer work at the Medical Center.

## **Dermatology**

Dermatology uses disposable instruments 99 percent of the time; on rare occasions they may require sterile instruments from SPD. The physicians and nurse practitioner in the clinic stated that on these occasions, instruments have been sterilized appropriately.

## **Emergency Room (ER)**

The team found the ER busy and left to avoid disrupting patient care. An interview was conducted with the Chief of ER, who indicated that neither he nor the other physicians in the ER have found issues with sterile instruments. They are always appropriately sterilized.

## **SPD**

The physical constraints of the preparation, sterilization, and decontamination does not lend to an efficient work flow. The staff in decontamination demonstrated their technique for handling of instruments and articulated the proper cleaning solution that was being used. Decontamination is staffed by three people. During the demonstration by the two SPD technicians, brushing and scrubbing of instruments occurred above the water level, when it should be below water. A contributing factor could be that the sink is extremely low and required constant bending over to accomplish this task. There is no cross training of SPD staff between decontamination and preparation. Each preparation station is equipped with magnified lights that are used by the staff to examine surgical instruments for bioburden/debris. They also indicated that they examine all instrument trays and peel packs after they are removed from the sterilizer, prior to being stored or sent to various departments. Any compromises to the packaging or bioburden/debris seen in the peel packs would require reprocessing and re-sterilizing the item(s).

## **Summary**

The issues with SPD and the reprocessing of RME has been a long-standing issue at the Medical Center. Complaints have been filed with Medical Center leadership, the OIG, and the Office of Special Counsel. These concerns include the inadequate reprocessing of instruments and the exposure of patient and staff to blood-borne pathogens. Several actions have been taken, including review, investigations, consultations, purchase of additional instruments, etc.; however these issues continue to surface. It is the opinion of this investigative team that more focus should be placed on the SPD department and its staff. The SPD needs an experienced Chief, Assistant Chief, Supervisor and lead technician

who understand the operations and requirements of SPD; all staff in the SPD should be fully trained and in-services on RME and other SPD issues be provided to this staff on a regular basis, preferably monthly basis. The physical constraint and lack of cross trained staff would make it extremely difficult to move all of RME to SPD to be reprocessed properly.

### **Conclusions Based on the Following Allegations**

**1. For five years doctors and staff at the Medical Center did not follow OSH SOP 3003 when they failed to sterilize medical instruments. Instruments are used on patients for procedures including minor surgery and then merely wiped with a Sani-Wipe and re-used on the next patient. Staff received clean instruments that actually had dried blood on them and/or sterile instruments that were not individually bagged to preserve sterilization. Staff regularly exhausts their supplies of clean instruments before they are finished seeing patient, and choose to reuse instrument to see more patients.**

Although the Medical Center does follow guiding principles outlined in OSH SOP 3003 and have taken several steps to improve the SPD's reprocessing of RME, there are still incidents of dirty, rust-stained instruments being sent to the clinics and operating room. The team substantiated that podiatrists in the podiatry clinic prior to 2006, did exhaust their supplies of clean instruments before they finished seeing patients and reused instrument to see another patients. This was corrected by the purchase of more instruments and sterilizing instruments after use.

**2. In the Ear, Nose, and Throat Clinic (ENT Clinic) nurses have been observed using trays of unsterilized instruments.**

The team did not substantiate that the nurses in the ENT clinic have used trays of unsterilized instruments.

**3. Staff received sterile instruments that actually have dried blood on them or sterile instruments are not individually bagged to preserve sterilization.**

The team substantiated that staff sometimes receives instruments that have been sterilized that have dried blood or other debris on them or that have problems with sterile packaging, with missing instruments, and are mislabeled.

**4. The lack of sterile instruments has led to patients and staff being exposed to infectious viruses and bacteria on a regular basis. As a result, thousands of veterans (many of whom have compromised immune systems) have potentially been exposed to a wide variety of infectious viruses and bacteria without their knowledge including: Human Immunodeficiency virus or HIV, hepatitis, methicillin-resistant Staphylococcus aureus (MRSA), bacterial-fungal, infections, and warts. Veterans have not been notified of their possible exposure or tested for any infection that may be a result of such exposure.**

There is a possibility that, in the podiatry clinic, patients may have been exposed to blood borne pathogens with the reuse of RME. None of the employees interviewed expressed concerns about being personally exposed to human immunodeficiency virus, hepatitis, methicillin-resistant Staphylococcus aureus, bacterial-fungal infections or warts.

**5. Management official are aware of this continuing public health danger but have taken no action to address the problem.**

Over the last several years, management has been acutely aware of the issue with SPD and reusable medical equipment and has taken many actions to resolve them; however some problems continue to exist.

#### **Violation/apparent violation of regulations, directives or policies**

The VHA team finding regarding violation/apparent violation of regulations, directives, or policies is that although there are opportunities to improve the reprocessing of RME, we found no violation/apparent violation of VHA or Medical Center regulations, directives, or policies.

#### **Recommendations**

1. The Medical Center must continue to examine the issues with RME in podiatry to determine why this section continues to have issues with their sterile instruments, i.e. quality of instruments purchased, elimination of reprocessing disposable instruments, appropriate use of chemicals in decontamination, appropriate use of the sterilizers, etc.
2. The Medical Center must hire, as planned, an experienced Chief and Assistant Chief of SPD and the six FTE that are being recruited as soon as possible.

3. The Medical Center should take immediate actions to assess the learning needs and provide training to staff in SPD to eliminate/minimize the errors that are occurring with RME reprocessing. Level 2 certification of staff should be encouraged and regular in-services to assist staff in obtaining/maintaining certification should be instituted immediately.
4. Ophthalmology should store their Gonio lenses in a container that can be cleaned effectively.
5. The Medical Center should consider cross-training and rotating staff between decontamination and sterile preparation areas to maximize support to SPD. Also ensure that training is provided by a competent instructor, that there is a training record for each SPD employee, and that documents all training, certificate and /or certification.
6. VHA should determine whether or not there needs to be an assessment of the podiatry patients seen by the contract providers, prior to the change in practice that occurred in 2006, the purchase of adequate numbers of instruments that allowed for appropriate sterilization after each individual patient use, for exposure to blood borne pathogens.
7. Management should continue to its efforts to improve SPD, through hiring as timely as possible and through close oversight.
8. The Team recommends that until the appropriated leadership is in place and the needed training completed, the facility not move any more RME processing into SPD.

#### **Actions Taken/Planned**

##### Actions Taken:

- RME Leadership rounds
- OR Committee that review instrument incidences
- RME Quality Oversight Committee
- Conduct an evaluation of the podiatry instruments

Actions Planned:

Recruitment of a Chief and Assistant Chief, SPD

Recruitment of six SPD staff persons

Recruitment of a quality management position for SPD

Proposed 14 day suspension of the employee mentioned above

Continued review of issue with podiatry instruments

Provide additional training to the SPD staff

VHA will determine whether patients seen by the contract podiatrist needs evaluation for exposure for bloodborne pathogens

Thank you for the opportunity to respond to this matter.

Eric K. Shinseki

**Kelley, Gloria A. (VHAJAC)**

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Friday, March 05, 2010 12:30 PM  
**To:** Simon, Joan A. (VHAJAC)  
**Cc:** Kelley, Gloria A. (VHAJAC)  
**Subject:** PPE Stored In Decontamination Area of the GI Clinic

Hello Joan,

Pursuant to VA Directive/Handbook 7176, Part 6. Decontamination, para. 3. 603 a.(4) – Long cuffed rubber/vinyl decontamination gloves (not surgical gloves). PPE will not be stored in the decontamination area as stated in Part 3. 603 b. line 5. The vinyl decontamination gloves are PPE and are therefore integral in the cleaning modality. Based on the current directive, it is imperative that areas outside of SPD with reprocessing responsibilities be in compliant with 7176. As I discussed my concerns with you earlier regarding gloves being the stored in the GI clinic, the PPE will need to be relocated into an area other than the decontamination area where endoscopes are being reprocessed. Any input you may have on this subject matter is greatly appreciated.

Thank you,

*Gloria A. Kelley*

Gloria A. Kelley, CRMST

Chief, SPD Intern

G.V. (Sonny) Montgomery VA Medical Center

1500 East Woodrow Wilson Drive

Jackson, MS 39216-5199

Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440

Fax: (601) 368-4171

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## **Kelley, Gloria A. (VHAJAC)**

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, March 23, 2010 2:09 PM  
**To:** Herbert, Billie S (VHAJAC)  
**Subject:** PPE

Hello Billie,

Here is the directive regarding the wear of personal protective equipment (PPE) per our conversation.

### **VA HANDBOOK 7176 August 16, 2002**

Personal protective equipment (PPE) is essential to an SPD technician's safety. Protective attire must be donned before entering the decontamination area. It is the technician's responsibility to understand the policies and procedures regarding protective attire in his/her work area or job assignment. Workflow should originate from outside the decontamination area and travel inside through a dedicated entry way and/or dumbwaiter/lift system.

#### **PERSONAL PROTECTIVE EQUIPMENT (PPE)**

a. Since the introduction of Universal/Standard Precautions, all used equipment and supplies are considered contaminated and must be treated as such. It is the medical center's responsibility to provide healthcare workers with PPE and training to promote personal safety. The medical center should also ensure that the employees wear the PPE. The types of PPE and restrictions used in SPD include:

- (1) Scrub Suits (not considered PPE; however, they allow changing as necessary).
- (2) Approved Head and Hair Covering.
- (3) Face Shields (cover from ear lobe to ear lobe and below the chin). If a face shield is not utilized, safety glasses/goggles will be worn with a surgical face mask.
- (4) Long Cuffed Rubber/Vinyl Decontamination Gloves (not surgical gloves)
- (5) Impervious Gown (this should be either disposable or reusable; long sleeved; fluid- impervious from elbows to cuff and from neck to bottom of gown; and length will be below the knee).
- (6) Impervious Shoe Covers (not paper shoe covers).
- (7) Jewelry is limited to wedding rings and post earrings.
- (8) False fingernails will not be permitted.

b. Personal protective equipment must be worn at all times in the decontamination area and must be removed whenever the technician leaves the area. After removing protective wear, the technicians must wash their hands. A fresh set of protective wear must be donned before reentering the decontamination room. Regular laundering and/or disinfecting of all reusable personal protective equipment is required to reduce cross-contamination. PPE will not be stored in the decontamination area.

*Gloria A. Kelley*  
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Chief, SPD Intern

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**Kelley, Gloria A. (VHAJAC)**

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, March 23, 2010 4:32 PM  
**To:** Herbert, Billie S (VHAJAC)  
**Subject:** Pre-Cleaning Protocol

Hello Billie,

During the SPD conference call this afternoon, there was discussion regarding the GI-Reprocessing Manual Customer letter dated February 19, 2010. The revised pre-cleaning protocol included the reduction in the amount of water being utilized and water used in lieu of an enzymatic solution in the pre-cleaning of endoscopes at the bedside after a procedure. Additionally, it was mentioned that this is an option available and that you may continue with the use of a detergent if you should so please. So, which every pre-cleaning protocol you may deem appropriate for your work center, please let the SOP reflect it as well. If I can be of further assistance to you please don't hesitate to let me know.

*Gloria A. Kelley*

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**G.V. "Sonny" Montgomery VA Medical Center**  
**March 30-April 1, 2010**  
**Clinical Site Visit**  
**DRAFT**

The purposes of this review were to assess the Quality Management System and generate a report to meet the requirements of the FY10 Deputy Undersecretary for Health Operations and Management (DUSHOM) Monitor. In addition, this review meets the oversight responsibility for the network office. Below is the summary of findings.

**QUALITY SYSTEM**

**Findings:**

- Informative annual Quality Management report that includes milestones for clinical, administrative and other business processes.
- Recommendations from the VISN QM review in FY09 were implemented.
- Dashboards are utilized throughout the facility that displays data over- time.

**Opportunities for Improvement/Recommendations:**

- Expand the use of targets and benchmarks to support data analysis. Several dashboards and spreadsheets did not have targets visually displayed (e.g. resident supervision, peer review).
- Update the illustration that depicts the committee structure to include CBOC and LTC committees.
- Update the QM plan to reflect the facility's adoption of VATAMMCS and add anticoagulation therapy as an internal monitor
- Expound findings from Utilization Management and Risk Management Programs (i.e. peer review, torts) to demonstrate a fully integrated Quality System and to assist Leadership with identification of organizational priorities.

**ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)**

*(Review of the OPPE process was limited to interviews: documents were not reviewed).*

**Findings:**

- The facility continuously improves this process

**Opportunities for Improvement/Recommendations:**

- There are no recommendations

**PEER REVIEW**

**Findings:**

- 25% of the cases screened are referred for peer review. This is within the VHA target.
- Tracking sheets support early identification of potential provider-specific problems.
- Inter-rater reliability procedures are established for occurrence screening to ensure a reliable process for identification of peer review cases. The IRR process is currently completed as a group. It is suggested that individuals complete the IRR before group discussion to improve the effectiveness of the process.

**Opportunities for Improvement/Recommendations**

- Continue to work toward meeting VHA target for completion of the initial peer review within 45 days. Failure to meet the 85% target is largely due to the volume of external peer reviews.

- Request a written extension from the Chief of Staff when a peer review is not completed within 45 days. (The number and reasons for extensions must be tracked by the Chief of Staff). This will likely be a SOARS recommendation.
- Request a written extension from the Center Director when a final peer view is not completed within 120 days. The Center Director is responsible for reviewing the number of extensions twice a year. This will likely be a SOARS recommendation.
- Complete an annual analysis of Level 3 peer review cases to identify potential at-risk patient care processes and integrate findings into the annual QM report.

## **RESIDENT SUPERVISION**

### **Findings**

- The facility reports that surgical residents are not involved in Level E and Level F incidents (*SOARS criteria requires 100 percent review of the appropriateness of Level E and F*)
- Resident supervision data show performance between 97% and 100%.
- Results of resident supervision monitoring is integrated into the provider profiles.
- There is documentation that resident supervision data, Learner's Survey results and other information sources are utilized to improve and support the resident's learning environment.

### **Opportunities for Improvement/Recommendations:**

- There are no recommendations.

## **MODERATE SEDATION (THERE WAS A LIMITED REVIEW OF MODERATE SEDATION)**

### **Findings:**

- The use of reversal agents is monitored by the Procedure Committee. There were two instances in one year when reversal agents were necessary.
- Two physician records were reviewed and both had current privileges in sedation and ACLS, which is a requirement, was also current.

### **Opportunities for Improvement/Recommendations :**

- There are no recommendations.

## **CUSTOMER SATISFACTION AND PATIENT ADVOCATE DATA**

### **Strong Practice:**

- Scripting Booklet "Improving Communication with Our Customers". This should be shared with other facilities.
- Collaboration between Customer Satisfaction and Patient Advocate Program.

### **Findings:**

- Multiple resources are used to communicate customer service results (Monthly News Letter, Town Hall Meetings, Stakeholder Meetings).
- A training DVD has been developed to assist staff improvements in their interaction with patients.
- Hourly rounds on inpatient units that are designed to reduce calls for assistance and reduce falls
- Four active system redesign teams are addressing customer service improvements.
- Facility has a local Fresh Eye team and findings are reported to the Customer Service Committee.

### **Opportunities for Improvement/Recommendations:**

- Request customer survey comments from the Office of Quality and Performance to assist with identification of improvement opportunities. The facility is meeting the Mission Critical Outpatient Satisfaction measure YTD but there is negative trend (66.7, 53.1, 50.4).
- The facility is not meeting Mission Critical inpatient Satisfaction Measures YTD but there is a positive trend.

#### **OPERATIVE AND INVASIVE PROCEDURE REVIEW**

##### **Findings:**

- The Operating Room Committee's membership includes member of the Quadrad. The minutes reflect review of a comprehensive set of metrics
- The Procedure Committee provides oversight of procedural areas.
- Good O/E Ratios for surgical mortality and morbidity. ENT has an OE ratio of 1.73 for morbidity. All cases were reviewed and appropriate actions implemented.
- Focused Provider/Procedure reviews have been completed as a result of OIP activities.

##### **Opportunities for Improvement/Recommendations:**

- Procedure Committee to provide oversight for Dental Services and determine if procedures are performed in CBOCs.
- Continue with plans to increase sample size to ensure an effective procedure review process.
- Add the Patient Safety (PS) Manager to the Procedure Committee since many of the findings related to PS.
- Complete an annual summary of findings from procedure review

#### **IPEC DATA**

##### **Findings:**

- The facility has assigned responsibility for review and oversight of IPEC data. There was a recent drill down analysis that is expected to assist with improvement of the national data reliability process.

##### **Opportunities for Improvement/Recommendations:**

- There are no recommendations. Continue with plans to increase understanding and use of IPEC data throughout the medical center.

#### **PERFORMANCE MEASURES**

##### **Strong Practice:**

- Multiple disciplines (nursing, pharmacy, dietetics, primary care, goal sharing team leaders, HBPC) participate in EPRP exit reviews. This contributes to the medical center's success with EPRP performance measures.

##### **Findings:**

- The Medical Center has discussed the possible need for a communication plan because of the release of public data
- The PM Dashboard is updated immediately after EPRP reviews.
- System Redesign Teams are chartered to improve measures related to Tobacco, Lipids and Hypertension

#### **Opportunities for Improvement/Recommendations:**

- There are no recommendations. Continue with action plans to improve measures that are not meeting target.

#### **CPR REVIEW**

##### **Findings:**

- Data is collected and critically analyzed.
- Opportunities for improvement and actions taken are identified and documented in minutes.
- Benchmark data is not being utilized.
- Current facility policy present for CPR/ACLS does not include actions for non-compliance. Policy states “all clinically active staff require BLS” – current data does not support this level has been accomplished.

#### **Opportunities for Improvement/Recommendations:**

- Implement the use of benchmark data on graphs.
- Suggestion: Standardize placing a summary on the analyzed data.
- Ensure facility policy is met for personnel required to have ACLS or BLS.
- Finalize and approve the draft policy concerning CPR/ACLS
- Ensure services are keeping tracking tools for CPR/ACLS training up to date.

#### **RAPID RESPONSE TEAM**

##### **Findings:**

- Process in place and effective.

#### **Opportunities for Improvement/Recommendations:**

- Suggest adding a summary to the graph “Non-ICU & Non-ED Codes vs RRT” to communicate the review of each Code indicated initiation of RRT was not required.

#### **MEDICAL RECORD REVIEW**

##### **Findings:**

- Limited interdisciplinary involvement in reviews (HIMS & Nursing only).
- All elements being reviewed appropriately.
- Minutes indicate data discussion and actions taken.
- Copy & pasting policy and monitoring indicate much improvement from last review. All criteria met.

#### **Opportunities for Improvement/Recommendations:**

- Suggest evaluating process for conducting reviews to expand interdisciplinary involvement.

#### **CONTINUED READINESS**

##### **Findings:**

- Thorough tracking tool in place for external reviews and actions for recommendations.
- Evaluated multiple areas including ER, PC Red, 4CN, 4CS, & CLC  
Issues with General Cleanliness – baseboards, thick dust, corners, supply rooms, house keeping closets, etc. (PC Red had significant improvements made)(Flooring\lower walls with stains, discolorations in first floor CLC)  
One air vent CLC with significant rust present (H136) & rare ceiling tile discoloration \*

Offices, closets, drawers, storage areas – cluttered, exterior shipping boxes, unable to be cleaned appropriately, outdated supplies.

Expired supplies in small numbers found.

Papers with patient names and full SSN present in drawer.

Possibility for privacy issues based on discussions with staff choosing to use full SSN for identification instead of other options such as date of birth

Medication Security for CLC with medicines being sent through tube system without nurse notification

Infection Control concerns with cracked mattress and furniture peeling in ER

Multiple areas with paint peeling, damage to sheet rock (primarily ER, one room 4CS 4289 has damaged area by window, baseboards not present in some areas of 4CS, but present in many other areas )

Outdated PI data posted (fy 08), listings for High Alert and Look Alike Sound Alike Meds are not current

Medication room dusty, sink unclean

Signage not present in PC Red

Ward Supply CLC lock broken (HB27)

Food/Drinks present in patient care areas

Computers, excess & broken equipment in storage areas

#### **Opportunities for Improvement/Recommendations:**

- In-depth cleaning of all areas- floors, lower walls, medication room shelves, supply rooms, etc.
- Ensure staff evaluate areas and enter appropriate requests for stained tile replacement, repair of wall damage, replacement of signage, return of equipment, and communication of other environmental needs.
- Ensure organization and cleanliness of all storage areas – drawers, cabinets, closets; this will help prevent pt privacy issues and outdated supplies.
- Continue staff education on patient identifiers/privacy issues for them to select another identifier other than the full SSN.
- Correct Medication Security issues for CLC with implementation of tube system security door or other process to ensure medications are not unsecured.
- Replace storage cabinets and cracked mattress in ER.
- Evaluate all posted PI data and posters to ensure they are current.
- Repair lock on supply room in CLC (HB27)
- Educate staff to NOT have food/drinks in patient care areas – including offices if patients receive care in the office.

#### **SYSTEMS REDESIGN**

##### **Findings:**

- Strong evidence of involvement of Senior Leadership in Systems Redesign activities and projects. Systems Redesign projects are championed by Pentad member. Funding is provided for participation in special national Systems Redesign training events, i.e., Access Partnership II, Patient Flow Coordination, Lean Thinking, etc.
- Strong evidence of integration of Systems Redesign improvement principles and tools throughout the medical center in clinical and administrative processes. Twenty-three SR teams are currently underway. Marked improvements can already be demonstrated by some teams.

- VA-TAMMCS improvement format has been adopted as the medical center's improvement model. Training on the format is offered to new employees at New Employee Orientation; to Leadership at Director's Staff Conference; to all levels of staff at Town hall meetings; and to Systems Redesign team members at the teams' first team meetings.
- Excellent understanding and implementation of ACA principles, processes, and tools within clinics and CBOCs. The facility's performance in "access to the 50 clinics within 30 days" is better than VHA and VISN means. Progress has been made in the cleanup of clinic profiles, and work is ongoing.

**Opportunities for Improvement/Recommendations:**

- Recommendation: Revise overall Performance Improvement Plan to include the VA-TAMMCS format, and include Systems Redesign as a component of the plan.
- Suggestion: Systems Redesign activities and metrics are currently reported to the Quality Executive Board. Considering the rapid growth of the Systems Redesign program, consider forming a Systems Redesign Committee to aggregate, coordinate, monitor, and trend all Systems Redesign projects, national Systems Redesign training opportunities, and metrics.
- Suggestion: Develop an overall Hospital Patient Throughput Policy, to readily demonstrate compliance with the Joint Commission Leadership Standard LD.04.03.11, "The hospital manages the flow of patients throughout the hospital."

**MRI SAFETY**

**Findings:**

- Excellent awareness by MRI staff and Imaging Leadership of unique MRI safety requirements. Signs to identify MRI Zones I, II, III, and IV have been posted. Access to Zones III and IV are controlled via badge or keypad access entry. A sign stating "The Magnet Is Always On" is posted.
- An MRI operations manual is available, containing safety and infection control protocols specific to MRI requirements. A Safety Training Checklist for non-MRI personnel was created, so as to ensure awareness and education on unique MRI safety requirements in Zones 3 and 4, and the checklist will be implemented..

**Opportunities for Improvement/Recommendation:**

- None.

**TRANSFUSION UTILIZATION PROGRAM**

**Findings:**

- Excellent understanding and implementation of VA Directive 2009-005, "Transfusion Utilization Committee and Program". The Transfusion Committee is comprised of a strong interdisciplinary team of subject matter experts, who continually and effectively oversee and monitor transfusion practices within the facility.
- Transfusion Committee minutes are thorough and complete, reflecting all required transfusion data and information, including discussion of issues, actions taken, and trending of findings.
- The peer review program addresses all required transfusion practices for all blood components. Providers with transfusions failing Quality Assurance review are rarely noted. However, protocol in those circumstances requires that written notifications be given to the provider, attending physician (if provider is a resident), and the Transfusion Committee Chair, and also requires written justification/response from the provider.

**Opportunities for Improvement/Recommendations:**

- None.

## **DIAGNOSTIC SERVICES – SOARS ASSESSMENT GUIDE**

### **Pathology and Laboratory Medicine Service:**

#### **Findings:**

- Excellent understanding and demonstration of quality laboratory practices.
- Excellent policies and procedures offer staff guidelines on performance of routine and STAT clinical and anatomic laboratory tests and procedures; performance of required maintenance and quality control on laboratory instrumentation; and special processes associated with abnormal and/or critical laboratory results.
- Excellent Quality Improvement Plan includes quality measures/monitors with established benchmarks, which ensure acceptable performance by all sections within the main and ancillary laboratories.

#### **Opportunities for Improvement/Recommendations:**

- Recommendation: 2010 Joint Commission Patient Safety Goals removed “Critical Tests”, i.e., the requirement to call normal results for specific tests identified by the facility as “Critical Tests”. Recommend that Laboratory Leadership consult with the Patient Safety Manager regarding modification of appropriate P&LMS and/or center policies.

### **Imaging Services:**

#### **Findings:**

- Strong understanding and implementation of quality and safety procedures within all imaging modalities.
- Excellent oversight and control of radiopharmaceuticals. Processes include strong security, transport, and disposal protocols, and ensure compliance with applicable regulations and safety of patients and employees.
- Excellent Radiation Safety program. The Radiation Safety Officer reviews all radiation monitoring badge reports for staff, and results are reported to the Radiation Safety Committee. Results are provided to staff, and annual exposure reports are mailed to each badged worker.

#### **Opportunities for Improvement/Recommendations:**

- Recommendation: Develop a written policy or procedure for specimen labeling in Interventional Radiology. The document should incorporate the patient’s full name and social security number in the labeling process, and should ensure all specimens are labeled only at the time of collection with the patient present and identification verified, so as to ensure accurate identification.
- Suggestion: Consult with subject matter experts regarding the need for eye wash stations within Imaging Services.

### **OEF/OIF Program**

#### **TBI Program**

#### **Findings:**

- The clinic is working effectively as a integrated care clinic meeting the needs of the OEF/OIF veterans.

- The TBI clinic is co-located within the clinic which is a plus.
- The psychiatry technician works with the physician to do the 2<sup>nd</sup> level TBI screen. The process works well, although the consults for the 2<sup>nd</sup> level screen are not received in the timely manner, affecting your performance measures.
- Staff work well together and utilize the strengths of the team effectively.

**Opportunities for Improvement/Recommendations:**

- Add "TBI" to the Post Deployment signage.
- Add patient complaints to your OEF/OIF dashboard
- Do a flow chart to map the process for receiving TBI consults; this procedure will give insight to the constraints in the process and reveal opportunities for improvement.

**ICU**

**Findings:**

- Areas clean and maintained.
- Cleaning supplies found in the medication room
- Computer left unattended with an open patient record.
- One multi-dose vial present without appropriate labeling

**Opportunities for Improvement/Recommendations:**

- Ensure all storage areas are clear of clutter and supplies
- Ensure all staff is aware that external reviews are being conducted so that they are on alert.
- Patient satisfaction box should be placed in the family waiting room.
- Suggestion: Begin patient care interdisciplinary conferences for patients in ICU longer than seven days to address all patient and family concerns.
- Suggestion: If hospital moving toward Magnet status, may implement shared governance of ICUs.
- Suggestion: Hourly vital signs may be captured in CPRS.

**UTILIZATION MANAGEMENT**

**Findings:**

- Report to be given by teleconference at a later date.

**COORDINATION OF CARE**

**Opportunities for Improvement/Recommendations:**

- Report to be given by teleconference at a later date.

**RME/SPD**

**Findings:**

**Strong Practices**

- The staff and leadership in SPD are very diligent in improving the processes and accountability for SPD area. I found the SPD proper areas to very clean and organized
- Evidence of no outdated were found in any of the secondary areas that I reviewed.
- OR Nurse Manager was present on the OR where I found several strong and one best practice. The best practice is the computerized preference card. One of the Staff nurses Keith Turnage had developed an incredible data base that allows the staff on any shift from any specialty area to

drill down to the preference cards and items needed for literally hundreds of surgical procedures with three clicks. This is invaluable for improving efficiency, reducing waste, and ensuring patient safety.

- One strong practice is the <sup>CyGIS</sup> Insta-track instrument tracking system has also improved the tracking and flow of instrument sets. The VISN sent out an action item a few weeks ago requesting SPD technology and best practices and these two practices are good examples and I would highlight these for the SOARS tour. I found really strong practices in the area of reducing flash sterilization, record keeping, SOPS, staff competencies, training, monitoring of supplies in the SPD proper areas.
- GI lab had their competencies in the 6 part folders, Scope room very clean, organized, scopes tagged for outdates, areas ~~was~~ extremely clean.
- The skin integrity program is excellent good minutes, tracking and trending.
- Strong SPD QI dashboard I would like to use as a template for other VISN facilities.

## Findings

### RME processing outside SPD

Cardiac cath, ultrasound, ENT, Podiatry, Ophthalmology, GI, Bronchoscopy and Urology.

### General

- Transporting contaminated items to the prep areas are not consistent. VA Handbook 7176 states that flexible endoscopes should be placed in a covered container and transported to the SPD decontamination area. If we perform processing outside of SPD we must ensure the same level of care in all areas. \_
- PPE Personal protective equipment. The PPE must be stored outside the Prep/decontam area and must be donned prior to entry into the denomination area. The staff verbalized the correct procedure but when asked to see the area they were not clear on this point and did not challenge this reviewer.

- Storage

- In most areas there were storage cabinets available for the various scopes, tee probes, cystoscopes, bronchoscopes however there was not a clear storage procedure for the trans-vaginal probes in ultrasound and GI.

- Space issues

- The processing area in urology, cardiac, and in one of the OR secondary areas has exposed pipes which unacceptable from handbook 7176.
- The Cysto area utilizes "High level disinfection", the room where this occurs has exposed pipes, filters from an old "silver recovery unit"

- ~~The OR room houses a Steris one sterilizer that is not presently being used. This room was dirty old glove boxes where the gloves were dry rotting, old instruments on soiled chux in a cabinet that was dirty. Exposed pipes on the wall.~~

- Cardiology has a special processor installed that appears to have some piping installed to access the water sources this is not optimal.

- SOP and competencies were found in all areas, there was a date missing on two <sup>competencies</sup> forms in the eye clinic and individual competencies needed to be completed for the ENT staff on the Olympus process and this was completed while we were on site.

- There were corrugated cardboard boxes in several of the unofficial SOD storage sites in these areas.

\* GI lab had specimens in the decontamination room but was not requiring the appropriate PPE to be worn when obtaining these specimens.

- Only one outdate was found in the primary SPD/logistics.

#### Operating Room

- General cleanliness needs to be improved, walls stainless steel cabinets, supply rooms had dust. Housekeeping closet was filthy had rusted carts, storage of clean items. Unique process was occurring. Taking clean drain tubing and cutting this from a large roll and attaching to a suction canister that was being stored in a plastic trash can (cleaning schedule not available) in the dirty soiled housekeeping closet. Cleaning requirements posted on wall were from 2006, two brooms and dust pan in closet. I asked for the housekeeping supervisor Mr. Alexander to come and see the area.
- Did not identify a formal implant log book or spreadsheet at present information is being recorded in the surgery package in the patients record.
- Supply closets in Anesthesia proper had corrugated cardboard, no outdates were found in any of these areas.
- Supply equipment closet there was some wire shelves without solid bottoms, corrugated cardboard, muslin sheets used to cover equipment.
- Omnicell in used but does not have the interfacing software.
- Two unofficial storage areas noted in the back of the operating room with multiple instruments, equipment and outdated supplies.
- Infection control nurse is not participated in EOC rounds for over 6 months due to time constraints.

#### Opportunities for Improvement/Recommendations:

- Primary concerns focused around processing of RME outside of SPD and cleanliness of the areas
- Recommend a centralized scope processing area within SPD so that scope processing in the outside areas can be moved.
- A mechanism for storing PPE outside these decontamination rooms needs to be implemented (i.e. wall ppe servers). Employees need to review the requirements for PPE in the decontamination area outside SPD.
- I would recommend that a cabinet be purchased for the ultrasound area to store the transvaginal probes.
- I would recommend the purchase of tags for each scope to clearly identify outdates.
- Transporting of contaminated items from procedure area to the processing area. At the minimum the items should be transported in a biohazard bag, totes or covered containers are considered best practices and will protect the equipment from damage and potential disposal.
- Operating room processing room. Recommend to either remove the Steris one machine from this room or clean up the room. By having the Steris one in this room and checking it every day it leaves the impression that it may still be in use.
- Housekeeping procedures in the operating room need to be updated and training needs to occur on a regular basis. Need to remove the clean supplies from the housekeeping closet and review the practice of placing clean suction canisters in the rooms after terminal cleaning. Improve terminal cleaning with focus on cabinet tops, corners of floors, steel cabinets, under sinks. This is where the majority of the issues were noted.

*Subject  
to be  
purchased*

- Supply closets in the OR that contain unofficial inventory need to be cleaned and organized. I would recommend covering equipment with plastic to reduce dust build up. Remove accession or bag infrequently used equipment. Old instruments need to be returned to SPD.
- Need to ensure solid bottom shelves in all supply racks Old equipment, instruments need to be removed.
- Remove corrugated cardboard from all processing areas outside SPD, supply closets in OR and anesthesia.
- Strongly recommend a second Infection Control nurse be added based on the size and complexity of the facility and the issues we identified related to environment of care cleanliness.
- Implants. Need to review processes and documentation for tracking non-biological implants to ensure the process meets the intent of the VHA directive on Non-biological implants.
- Recommend evaluating staffing levels of WOC Nurses due to the complexity and size of the facility.

## **ADVERSE EVENT DISCLOSURE**

### **Findings:**

- Disclosure log present and maintained between Patient Safety and Risk Manager
- Some disclosures were not timely; explained as being a result of outside reviews.
- Questions/concerns over same event having differing disclosures (clinical vs institutional)

### **Opportunities for Improvement/Recommendations:**

- Ensure like events have the same type of disclosure (as identified by CAP)

## **PATIENT SAFETY**

### **Findings:**

- Strong Practice: Daily plan implemented on Surgical Ward
- Strong Practice: Implementation of electronic Patient Incident Reporting System.
- Patient Safety Committee recently formed and has one set of minutes available for review; multiple imbedded documents with limited discussion present in minutes.
- Since the last PS visit, RCAs have been completed within the designated time frames; strength of actions have become stronger.
- Staff able to articulate process changes applicable to their areas as a result of RCAs.
- PI information displayed on wards need to be current (fy 08 present)
- HFMEAs completed annually and covers all programs; however, staff unable to articulate knowledge of topic or actions of fy 09 HFMEA.
- Past due actions/outcome measures open in SPOT (from Feb.) -
- Patient Safety has developed a spreadsheet to track RCA actions and outcome measures that includes monitoring of ongoing compliance.

### **Opportunities for Improvement/Recommendations:**

- Improve the format of the Patient Safety Committee Minutes by adding more discussion and specifying actions which are pending/closed.
- Ensure PI information displayed on wards has current data present.
- Educate staff on topic and process changes as a result of the last HFMEA.

- Improve tracking mechanism for Actions/Outcome Measures of RCAs – suggested to include in Patient Safety Committee Minutes.
- Close out past due actions/outcome measures in SPOT

Review of patient care areas – 2AN, 2AS, 3K, & Hemodialysis

- Unsecured construction site on 3<sup>rd</sup> floor and 2AS.
- Open 8oz containers of soap on inpatient Mental Health (in patient's room). full
- 2AN full oxygen containers did not have seals to indicate they had not been used.
- Patient very complimentary of daily plan in his.
- Overall cleanliness of floors, especially corners , edges, and equipment in General areas (not including units).
- Include the tracking of RCA and HFMEA actions and outcome measures in the Patient Safety Committee minutes.

## WOMEN'S HEALTH

### Findings:

- The Women Veterans Program Manager, assumed this full time position in August, 2009. She is very conscientious, astute and compassionate in establishing and improving standards of care for women veterans. She is a member of the VISN 16 Safety and Privacy Group and has worked with EMS in quickly improving provisions in the environment of care as placement of baby changing stations and a process for the provision of sanitary napkins / tampons for women veterans.
- **Opportunities for Improvement/Recommendations:**
  - Lack of auditory privacy at check-in PC Blue Clinic (Women's Clinic location).
  - Lack of privacy curtains in inpatient private rooms.

*There are actions in place to address both deficiencies. Extenda Barriers and Privacy Curtains are in the purchase process. Vendor for curtains measured all out patient exam rooms last week and will return to measure inpatient units next week. The Extenda Barriers were ordered on 3/19/10 and should arrive by 4/15/10. (Validated report from Interior Designer)*

*A Women's Comprehensive Health Center is proposed for construction in the PC Blue Clinic area. This would greatly improve overall services for Women Veterans.*

### Hattiesburg CBOC

#### Opportunities for Improvement/Recommendations:

- Lack of auditory privacy at check-in.
- Changing tables are not available.
- Although there is restriction to the exam room hallways, the restroom is not located adjacent to the exam room for women to easily access if gowned. The restroom is located on a hallway between exam rooms used for both male and females as well as staff. Tracks needed to hang Privacy Exam curtains in exam rooms.

*There are actions in place to address both deficiencies. Privacy curtains are in the clinic's possession and tracks will be installed soon. A changing station has been ordered and an Extenda Barrier will be ordered.*

*The Clinic will undergo remodeling soon and the Clinic Manager has plans to designate one exam room for women procedures with a restroom attached. All providers will use this room for women patient procedures.*

*The Clinic Manager is very proactive in providing quality patient care services as reflected in the positive clinic milieu, efficient scheduling and her plans to improve privacy for all patients.*

**Kelley, Gloria A. (VHAJAC)**

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Friday, March 26, 2010 2:05 PM  
**To:** Smith, Johnny Lee (VHAJAC)  
**Cc:** Simon, Joan A. (VHAJAC)  
**Subject:** RME Binder

Good afternoon Johnny,

In order to complete our SPD RME binder, the following information is needed: 1) a copy of the manufacturer's guidelines for the endoscopes that are being reprocessed in your area. If the several or all scopes have the same reprocessing protocol, only one copy of the manufacturer's guidelines will be required. 2) the training sheets which indicates the date training occurred on each endoscope per trainee, and 3) the competency assessment sheets on each staff member responsible for reprocessing RME.

Your help in this matter is greatly appreciated.

Thank you,

*Gloria A. Kelley*  
Gloria A. Kelley, CRMST  
Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
Fax: (601) 368-4171

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**Acosta, Carla L. (VHAJAC)**

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**From:** White-Taylor, Dorothy M. (VHAJAC)  
**Sent:** Monday, July 05, 2010 12:07 AM  
**To:** Simon, Joan A. (VHAJAC); Acosta, Carla L. (VHAJAC); Garner, Rosa T. (VHAJAC); Snell, Valerie E (VHAJAC); Rucker-White, Thantween S. (VHAJAC)  
**Cc:** White-Taylor, Dorothy M. (VHAJAC); Bruce, Lisa B. (VHAJAC)  
**Subject:** Dental RME

**Importance:** High

Just thinking of my visit to our Dental Office off of 220 on Friday.

Dental has quite a bit of RME. All of the suction, probes, "stuff" on the sides of the dental chairs, the dental chair, the head rest of the dental chair, etc.

I thinking, I did not see SOPs, manufacturers' instructions, or competencies for this equipment.

"Houston I think we have a problem!!!!!!".

Please "jump" on this as a group 1st thing Tuesday and fix it - before VA, OMI, OIG, or anyone else comes to review / survey - like they think someone will starting on Tuesday.

D

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Sent from my BlackBerry Wireless Handheld

**Kelley, Gloria A. (VHAJAC)**

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Wednesday, July 07, 2010 11:46 AM  
**To:** Simon, Joan A. (VHAJAC)  
**Subject:** Emailing: Cavitron\_Reservior  
**Attachments:** Cavitron\_Reservior.pdf

**Kelley, Gloria A. (VHAJAC)**

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Wednesday, July 07, 2010 1:16 PM  
**To:** Simon, Joan A. (VHAJAC)  
**Subject:** Basic Dental Inst-Revised  
**Attachments:** Basic Dental Inst-Revised.doc

**Kelley, Gloria A. (VHAJAC)**

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Thursday, July 08, 2010 8:41 AM  
**To:** Simon, Joan A. (VHAJAC)  
**Subject:** FW: Cleaning and Sterilizations Instructions for Dentsply Cavitron Inserts  
**Attachments:** Dentsply Cavitron Insert Instruments (Cleaning and Sterilization).pdf

Joan,

Per our discussion

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**From:** DuPlooy, Leslie [<mailto:Leslie.DuPlooy@dentsply.com>]  
**Sent:** Tuesday, July 06, 2010 6:14 PM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Subject:** Cleaning and Sterilizations Instructions for Dentsply Cavitron Inserts

Gloria,

Please see the attached cleaning and sterilization instructions for Dentsply Cavitron Inserts. Please do not hesitate to contact me if you need anything.

Regards,

Leslie

Leslie du Plooy  
Dentsply International  
Federal Government Division  
Southeast Region Manager  
US Cell -504-400-1434  
International Cell - 504-616-3356

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**Kelley, Gloria A. (VHAJAC)**

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**From:** Simon, Joan A. (VHAJAC)  
**Sent:** Tuesday, July 13, 2010 4:06 PM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Subject:** RE: DENTAL CLINIC

Dental has their own budget

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, July 13, 2010 9:36 AM  
**To:** Simon, Joan A. (VHAJAC)  
**Subject:** FW: DENTAL CLINIC

Joan,

What should be the procedure for purchasing instrumentation by SPD, when does this occur, for which services, from whose budget, what about replacement instrumentation, instrumentation requiring repair/retiring from inventory, etc.

Please advise,

Thank you,

*Gloria A. Kelley*

Gloria A. Kelley, CRMST  
Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
Fax: (601) 368-4171

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**From:** Eldridge, Paula (VHAJAC)  
**Sent:** Monday, July 12, 2010 2:01 PM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Subject:** DENTAL CLINIC

Gloria:

Per our conversation on last Tuesday:

This is a list of instruments needed in order for SPD to have enough turn-around time

Thanks!

*Paula B. Eldridge, CDA/c/a*

*Paula B. Eldridge, CDA  
6522 Dogwood View Parkway  
Jackson, MS 39213  
Office: 601-364-1294  
Fax: 601-362-0044  
E-mail: [Paula.Eldridge@va.gov](mailto:Paula.Eldridge@va.gov)*

**Kelley, Gloria A. (VHAJAC)**

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**From:** Arnold, Marsha C (VHAJAC)  
**Sent:** Friday, July 16, 2010 10:38 AM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Cc:** Simon, Joan A. (VHAJAC); Acosta, Carla L. (VHAJAC)  
**Subject:** RE: policy temp humidity SPD

May I have a copy? Thanks.

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Friday, July 16, 2010 10:17 AM  
**To:** Arnold, Marsha C (VHAJAC)  
**Cc:** Simon, Joan A. (VHAJAC); Acosta, Carla L. (VHAJAC)  
**Subject:** RE: policy temp humidity SPD

Yes, there is one in each of the functional areas.

---

**From:** Arnold, Marsha C (VHAJAC)  
**Sent:** Friday, July 16, 2010 8:42 AM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Cc:** Simon, Joan A. (VHAJAC); Acosta, Carla L. (VHAJAC)  
**Subject:** RE: policy temp humidity SPD

Thanks, do you already have a log made up also?

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Thursday, July 15, 2010 4:10 PM  
**To:** Arnold, Marsha C (VHAJAC)  
**Cc:** Simon, Joan A. (VHAJAC); Acosta, Carla L. (VHAJAC)  
**Subject:** policy temp humidity SPD

Hello Marsha,

Per your request,

*Gloria A. Kelley*

Gloria A. Kelley, CRMST

Chief, SPD Intern

G.V. (Sonny) Montgomery VA Medical Center

1500 East Woodrow Wilson Drive

Jackson, MS 39216-5199

Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440

Fax: (601) 368-4171

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**Kelley, Gloria A. (VHAJAC)**

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Monday, July 26, 2010 10:21 AM  
**To:** Simon, Joan A. (VHAJAC)  
**Cc:** Kelley, Gloria A. (VHAJAC)  
**Subject:** Competency Assessment Glidescope  
**Attachments:** Competency Assessment Glidescope.doc

**Kelley, Gloria A. (VHAJAC)**

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Monday, July 26, 2010 10:26 AM  
**To:** Acosta, Carla L. (VHAJAC)  
**Subject:** ACMI Flexible Ureteropyeloscope DUR-8  
**Attachments:** ACMI Flexible Ureteropyeloscope DUR-8.doc

**Kelley, Gloria A. (VHAJAC)**

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**From:** White-Taylor, Dorothy M. (VHAJAC)  
**Sent:** Tuesday, August 10, 2010 11:51 PM  
**To:** Watson, Linda F. (SES) (VHAJAC); VHAJAC RME (Reusable MED Equipment)  
**Cc:** White-Taylor, Dorothy M. (VHAJAC)  
**Subject:** RE: Heads Up from Mytle Tate

Each survey has had some of the SOPs reviewed line by line and word by word.

The only difference this time is that it will be ALL SOPs.

All areas were informed prior to last review even though we did not know it would be all SOPs.

It is expected that:

- the SOPs will be congruent with/following the manufacturers' instructions
- the competencies are congruent with the SOPs – step for step

Particular attention should be given to dates on the SOPs, training records, and competencies. The SOPs should be the earliest date (and should be approved by the Acting Chief of SPD and the IC), the training date should be after the date of the SOP and approval date, and the competencies should be dated after the training date or on the same day of the training date.

These are also the items being checked on RME rounds – routine and executive.

Historical documents should be maintained to show evidence of prior SOPs, training, and competencies.

---

**From:** Watson, Linda F. (SES) (VHAJAC)  
**Sent:** Tuesday, August 10, 2010 9:58 AM  
**To:** White-Taylor, Dorothy M. (VHAJAC)  
**Cc:** VHAJAC RME (Reusable MED Equipment)  
**Subject:** FW: Heads Up from Mytle Tate

FYI

They will look line for line to see if our information is accurate

Pls advise

---

**From:** Lack, Regina C (VHAJAC)  
**Sent:** Tuesday, August 10, 2010 9:32 AM  
**To:** Watson, Linda F. (SES) (VHAJAC)  
**Subject:** Heads Up from Mytle Tate

Ms. Watson

Myrtle Tate called me this morning and will be sending an e-mail with the following information.

The VISN will visit next week to look at RME from Tuesday-Thursday (and Friday if needed). Her goal is to have all SOPs updated and training (if needed) done before VISN leaves.

She would like:

- One location to review information
- At least 2 employees available to type/make corrections to SOPs as VISN reviews

## Kelley, Gloria A. (VHAJAC)

---

**From:** Watson, Linda F. (SES) (VHAJAC)  
**Sent:** Thursday, August 12, 2010 3:03 PM  
**To:** VHAJAC RME (Reusable MED Equipment)  
**Subject:** FW: Follow up RME Visit

---

**From:** Tate, Myrtle (V16)  
**Sent:** Tuesday, August 10, 2010 5:09 PM  
**To:** Lack, Regina C (VHAJAC)  
**Cc:** Watson, Linda F. (SES) (VHAJAC); Scott-Williams, Susan; Bowling, John H.; Smith, Amy W. (V16)  
**Subject:** Follow up RME Visit

Gina  
Suzie Scott-Williams, Network SPD Consultant came by yesterday to discuss our return RME visit to your facility Below is the summary of the information you will need to coordinate the visit.

Team members are Myrtle Tate, Suzie Scott-Williams and John Bowling (Chief SPD Biloxi). We will arrive at 8am on August 17, 2010 and expect to complete the review by Thursday, August 19. If we are unable to complete the review, we will return on Friday August 19, 2010. Can you please arrange parking for three cars?

The team will verify that all SOPs, competencies and training has been completed based on your Master List. To accomplish this task, we are requesting a room large enough for the three reviewers as well as three to five staff who can assist with correcting the SOPs. We will need to re-review and validate all corrections to SOPs and subsequent training and competency assessment, if needed.

Suggest you assign at least two typists and persons to work with each reviewer. Please have three copies of the Master List (one for each reviewer). This is a status of the review:

1. Anesthesia/OR – will need to review all SOPs, competencies and training
2. Audiology – complete
3. Bronch/Respiratory – need to see changes in SOPs based on the previous review and validate competencies and training
4. Cardiac Cath – need to review changes based on the previous review and validate competencies and training
5. Dental – need to see new SOP for pre-treatment of dental instruments based manufacturer's instructions and related competencies and training; Need to see temperature and humidity monitoring logs and verify that dental does not do any packaging of clean instruments.
6. Dermatology – complete
7. ENT – need to see changes in SOPs based on previous review to ensure these match manufacturer's guidelines and validate appropriate updates to competencies and training – LaToya Readus has notes
8. Eye – need to verify manufacturer's guidelines have been received and a listing to show that all items in SOPs are covered by the manufacturer's guidelines – LaToya Readus has the notes; need to verify that the rinse step has been added to the competency of the B Scan Probe; verify that competency and training is completed for all employees ( one employee did not have this year's competency completed)
9. GU –review all SOPs, competencies and training
10. GI –review all SOPs, competencies and training
11. Hemodialysis – review SOPs, competencies and training
12. Sleep lab – uses disposables-complete
13. SPD – review most SOPs, competencies and training

14. Radiology – review SOPs, competencies and training
15. Podiatry – review changes in SOPs and validate competencies and training
16. Women's clinic – uses disposables - complete

VISN#: 16

Facility: G.V. (Sonny) Montgomery VAMC

Report Dates: July 22 - 23, 29, 2010  
August 17 - 20, 2010

Priority	Issue / Recommendation	Action Plan	Responsibility	Target Date	Status of Actions
<b>Key: 1 = Highest Priority</b>					
II.	<b>General</b>				
2	a. Reduce the number of products (i.e. enzymatic detergents, germicidal and disinfectants) if possible, to reduce the need for training on a variety of products.	Review is underway by the Infection Control Committee to further reduce the variety of products which will be discussed at the next IC committee meeting.	IC Nurse	10/28/2010	OPEN
1	b. Monitoring of temperature and humidity in Dental was recently initiated. The facility should develop a long term plan to address out of range temperature and humidity in Dental. The temperature has been as high 100 F. The area has been assessed by facility engineering and a portable de-humidifier was purchased; staff have been trained to observe for sterility of packing.	Temperature/Humidity monitor installed. Facility central air unit is now programmed to operate on weekends within the storage area. Responsibility of facility has been fulfilled.	Dental Chief Dental A/O	7/6/2010	CLOSED
II.	<b>General</b>				
1	d. Recommend re-emphasis on the importance of the appropriate cleaning and sterilization of instruments, i.e., distinguishing between thermal and chemical disinfection, and disinfectant products vs. detergent.	Completed during competency renewal.	Acting Chief SPD	8/20/2010	CLOSED

VISN#: 16

Facility: G.V. (Sonny) Montgomery VAMC

Report Dates: July 22 - 23, 29, 2010  
August 17 - 20, 2010

Priority	Issue / Recommendation	Action Plan	Responsibility	Target Date	Status of Actions
II.	General				
1	e. Temperature and humidity monitoring is not occurring in one MICU sterile supply rooms. Recommend the facility identify all areas where sterile supplies are stored and implement humidity and temperature monitoring to help protect the integrity of sterile packaging.	Completed.	Chief IMD	9/21/2010	CLOSED
3	f. SOPs are divided by process (pre-treatment, decontamination and sterilization). It is recommended that the facility integrate all process steps into a single SOPs ( at the next re-write). This will support your goal of cross-training, avoid gaps at the point of hand-off, and improve clarity of the process for employees as well as external reviewers.	Completed on site.	Acting Chief SPD	9/3/2010	CLOSED
3	h. Standardize the competency documentation process used throughout the facility. (Recommend GI's process.) This will support a system for tracking which employees have completed competencies (numerator and denominator).	Upon renewal of competencies, the remaining 7 areas' competencies will be standardized according to GI.	Acting Chief SPD	GU (Cysto): 4/2011 ENT, US, Eye: 6/2011 Respiratory, GU: 7/2011 Cath Lab: 10/2010	OPEN
2	k. Establish index of SOPs related to processing of critical and semi-critical instruments. This will help clarify areas where pre-treatment is performed.	Master List completed. All critical and semi-critical SOPs completed.	Acting Chief SPD	7/22/2010	CLOSED

VISN#: 16

Facility: G.V. (Sonny) Montgomery VAMC

Report Dates: July 22 - 23, 29, 2010  
August 17 - 20, 2010

Priority	Issue / Recommendation	Action Plan	Responsibility	Target Date	Status of Actions
2	i. In general, SOPs for the SPD location were more difficult to follow because the steps in the SOPs were not always in the same sequence as the manufacturer instructions. Recommend SOPs follow the sequence as outlined in the manufacturer instructions and clearly indicate when deviations are made for local policy reasons.	Completed on site.	Acting Chief SPD	8/20/2010	CLOSED
<b>VIII. SPD</b>					
2	b. ADPCS plans to establish a procedure of logging failures for monitoring/tracking/and trending problems with the washer/disinfector.	Tracking and trending procedures implemented.	AD/PCS	8/20/2010	CLOSED
2	e. ETO: There is a random assessment of the staff using the ETO sterilizer to check for low level contamination but very little on staff safety such as the process required should the area alarm signals a leak.	Documentation of staff safety processes for the ETO alarm are present on the door of ETO room.	Acting Chief SPD	7/22/2010	CLOSED
1	i. The facility has an Acting SPD Chief and has been recruiting for a Chief for an extended time. Continue with recruitment efforts. This is an outstanding recommendation from the OMI report.	Continue recruitment of SPD Chief	AD/PCS	Pending	OPEN
1	j. Reprocessing continues to occur outside of SPD in GI, GU, ENT and etc. Limited staff and space prevents moving all processing to SPD. The facility has submitted a waiver and is waiting for a decision from the Network Office.	Requesting redesign and SPD renovation. Currently reviewing workflow in the area. No decision on waiver.	AD/PCS	Pending	OPEN

VISN#: 16

Facility: G.V. (Sonny) Montgomery VAMC

Report Dates: July 22 - 23, 29, 2010  
August 17 - 20, 2010

Priority	Issue / Recommendation	Action Plan	Responsibility	Target Date	Status of Actions
2	m. With centralization of SPD training and oversight, consider off loading some of the responsibilities for the Chief of SPD (i.e. could send another employee to be a certified trainer). The Acting Chief SPD is responsible for checking competencies for all employees in all locations.	Plan to hire SPD Educator, developing functional statement.	AD/PCS	Pending	OPEN

VISN#: 16

Facility: G.V. (Sonny) Montgomery VAMC

Report Dates: July 22 - 23, 29, 2010  
August 17 - 20, 2010

Priority	Issue / Recommendation	Action Plan	Responsibility	Target Date	Status of Actions
VIII.	SPD				
1	o. Establish a document control process for SOPs and RME minutes. During the review, it was observed that the RME minutes had to be recreated and pages to documents were missing from SPD books. Facility to consider using PDF for current, approved SOPs and competencies.	QM will continue to keep a completed signed copy of monthly minutes which are audited by QM liaison. An additional PDF Share Portal was developed on site and merged with the current RME Policy page for SOPs. Corrections are completed and are in the process of being uploaded. QM Liaison is available to assist in the conversion process and uploading the current SOPs and competencies.	QM AD/PCS	Pending	OPEN
	q. Major revisions on 15/48 SOPs and competencies.	SOPs corrected and competencies completed.	Acting Chief SPD	8/20/2010	CLOSED
	r. Clarify the owner of the Master List and have one integrated list, regardless of what service originates the item that require sterilization. For example, if SPD is processing dental instruments, these items should appear on the SPD list, rather than a tab labeled dental.	SPD is maintains the Master RME list.	Acting Chief SPD	7/22/2010	CLOSED
2	s. Develop an SOP and check competency of staff on use and limitations of use for enzymatic cleaners, disinfectants and similar products used in re-processing.	SOP completed for all cleaners.	Acting Chief SPD	8/17/2010	CLOSED

VISN#: 16

Facility: G.V. (Sonny) Montgomery VAMC

Report Dates: July 22 - 23, 29, 2010  
August 17 -20, 2010

Priority	Issue / Recommendation	Action Plan	Responsibility	Target Date	Status of Actions
1	t. Add all manufacturer's guidelines for stainless steel instruments (with and without lumens) for SOP books 33 and 44 .	Completed on site.	Acting Chief SPD	8/17/2010	CLOSED
XI.	<b>ENT Clinic</b>				CLOSED
2	b. Staff state rigid scope was going to be reprocessed in SPD , but due to SPD staffing and space the reprocessing remains in ENT. The use of Cidex as a manual cleaning by ENT staff is a significantly lower efficacy processing method.	Facility to develop a plan to address space and staffing issues, so that rigid ENT scopes can be reprocessed in SPD.	AD/PCS	Pending	OPEN

# PREP/ADMIN SCHEDULE

Date: May 15-21

EMPLOYEE NAME	SUN	MON	TUES	WED	THUR	FRI	SAT
<b>6:00am – 2:30pm</b>	15	16	17	18	19	20	21
EVANS, PHILLIP (CC)	D						D
<b>10:00am – 6:30pm</b>	D						D
YAWN, JOE (CC)					PAL		
<b>7:00am-3:30pm</b>							
ACOSTA, CARLA (ASST. CHIEF)	D						D
SIMON, JOAN (EDUCATOR)	D						D
HARRIS, LYNN (LEAD/CC/O)	D						D
JOHNSON, DIANN	D						D
JONES, BRINDA	D	OC	OC	OC	OC	OC	OC
BROWN, ANTYON	D						D
THOMPSON, W. BURKE	OC						D
HARRIS, MICHAEL	D	CC	CC	CC	CC	CC	D
<i>Manning Resino</i>	D						D
<b>7:30am – 4:30pm</b>							D
COLE, DAMON (PSA)	D						D
KELLEY, GLORIA	D	PAL	PAL	PAL	PAL	PAL	D
<b>12:00N – 8:30pm</b>							
TIDWELL, CATINA (CENSITRAC/PREP)	D	OC	OC	OC	OC	OC	OC
HOWELL, JOE	D						D
BRAZIL, MIKE	D						D
KIRBY, RALPH	OC						D
LAWSON, RUBY							

CASE CART – CC  
ON CALL – OC

PLANNED SICK LEAVE - PSL  
PLANNED ANNUAL LEAVE – PAL

Certified Correct  
Posted

*4/20/12*

# DECONTAM SCHEDULE

Date: May 15-21

EMPLOYEE NAME	SUN	MON	TUES	WED	THUR	FRI	SAT
<b>7:00AM - 3:30PM</b>	<b>15</b>	<b>16</b>	<b>17</b>	<b>18</b>	<b>19</b>	<b>20</b>	<b>21</b>
PETERSON, STACEY	D				AL	AL	D
JONES, D'ANDRE <del>██████████</del>	D						D
NETTLE, JOYCELYN (AGENCY)	D						D
<del>COUNTRY, JOE</del> <i>Joe Anna</i>	D						D
<b>8:00AM - 4:30PM ENT/EYE</b>							
<del>██████████</del> <i>Jones, D'Andre</i>	D						D
SCOTT, WILLIAM	D						D
<b>8:00AM - 4:30PM 4<sup>TH</sup> FLOOR</b>							
HENRY, BELINDA	D						D
SYLVESTER, FRANSHA (AGENCY)	D						D
<b>8:00AM - 4:30PM GI</b>							
COOK, GERALD (AGENCY)	D						D
FISHER, BERTHA <i>Collins, Gerard</i>	D			2:30-4:30			D
<b>10:00AM - 6:30PM</b>							
RUSSEL, SHENELDER	D				7A-3 <sup>30</sup>	7A-3 <sup>30</sup>	D
COLLINS, GERARD <i>Fisher, Bertha</i>	D						D
<b>12:00N - 8:30pm</b>							
BROWN, JOHN	D						D
WATKINS, GINNY	D						D
<b>3:30P-12M</b>							
THOMPSON, HARRY	D						D
<del>██████████</del>	D						D
CARTER, MAURICE (DETAILED)	D						D
BRADLEY, JANICE (ML)	D						D

ORIENT - O  
 PLANNED ANNUAL LEAVE - PAL  
 PLANNED SICK LEAVE - PSL  
 Certified Correct  
 Posted

*4/29/20*

# PREP/ADMIN SCHEDULE

Date: May 22-28

EMPLOYEE NAME	SUN	MON	TUES	WED	THUR	FRI	SAT
<b>6:00am – 2:30pm</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>25</b>	<b>26</b>	<b>27</b>	<b>28</b>
EVANS, PHILLIP (CC)	D						D
MANNING, REGINA (CC)	D						D
<b>10:00am – 6:30pm</b>							
YAWN, JOE	D	<del>OC</del>	<del>OC</del>	<del>OC</del>	<del>OC</del>	<del>OC</del>	<del>OC</del>
<b>7:00am-3:30pm</b>							
ACOSTA, CARLA (ASST. CHIEF)	D	TVL	TVL	TVL	TVL	PAL	D
SIMON, JOAN (NURSE ED)	D	TVL	TVL	TVL	TVL		D
HARRIS, LYNN (LEAD/CC)	D	<del>OC</del>	<del>OC</del>	<del>OC</del>	<del>OC</del>	<del>OC</del>	<del>OC</del>
LAWSON, RUBY	D						D
JONES, BRINDA	OC	OC	OC	OC	OC	OC	OC
HARRIS, MICHAEL	D						D
THOMPSON, W. BURKE	D						D
BROWN, ANTYON	D						D
<b>7:30am – 4:30pm</b>							
COLE, DAMON (PSA)	D			PAL	PAL	PAL	D
<b>12:00N – 8:30pm</b>							
HOWELL, JOE	D	PSL					D
TIDWELL, CATINA (CENSITRAC/PREP)	OC						D
JOHNSON, DIANN	D						D
BRAZIL, MIKE	D						D
KIRBY, RALPH	D						D

ORIENT – O  
ON CALL – OC

CASE CART – CC  
PLANNED ANNUAL LEAVE – PAL  
PLANNED SICK LEAVE – PSL

Certified Correct  
Posted



## DECONTAM SCHEDULE

Date: May 22-28

EMPLOYEE NAME	SUN	MON	TUES	WED	THUR	FRI	SAT
<b>7:00AM - 3:30PM</b>	<b>22</b>	<b>23</b>	<b>24</b>	<b>25</b>	<b>26</b>	<b>27</b>	<b>28</b>
PETERSON, STACEY	D	PAL	PAL				D
NETTLE, JOYCELYN (AGENCY)	D				<i>leave</i>	<i>leave</i>	D
RUSSEL, SHENELDER	D						D
GUNTER, JOE ANN	D						D
<b>8:00AM - 4:30PM ENT/EYE</b>							
JONES, D'ANDRE	D						D
SCOTT, WILLIAM	D						D
<b>8:00AM - 4:30PM 4<sup>TH</sup> FLOOR</b>							
HENRY, BELINDA	D						D
SYLVESTER, FRANSHA (AGENCY)	D						D
<b>8:00AM - 4:30PM GI</b>							
COOK, GERALD (AGENCY)	D						D
FISHER, BERTHA	D					<i>PAL</i>	D
<b>10:00AM - 6:30PM</b>							
COLLINS, GERARD	D					<i>PAL</i>	D
	D						D
<b>12:00N - 8:30pm</b>							
BROWN, JOHN	D						D
WATKINS, GINNY	D						D
<b>3:30P-12M</b>							
THOMPSON, HARRY	D						D
CARTER, MAURICE (DETAILED)	D						D
BRADLEY, JANICE (ML)	D						D

ORIENT - O

PLANNED ANNUAL LEAVE -PAL

PLANNED SICK LEAVE -PSL

Certified Correct

Posted

*4/28/11* 

# PREP/ADMIN SCHEDULE

Date: May 29- June 4

EMPLOYEE NAME	SUN	MON	TUES	WED	THUR	FRI	SAT
<b>6:00am – 2:30pm</b>	<b>29</b>	<b>30</b>	<b>31</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>
EVANS, PHILLIP (CC)	D	H	AL				D
MANNING, REGINA (CC)	D	H					D
<b>6:00am – 2:30pm</b>							
YAWN, JOE (CC)	OC	H					D
<b>7:00am-3:30pm</b>							
ACOSTA, CARLA (ASST. CHIEF)	D	H					D
SIMON, JOAN (NURSE ED)	D	H	PAL	PAL	PAL	PAL	D
HARRIS, LYNN (LEAD/CC)	OC	H					D
JOHNSON, DIANN	D	H/OC	OC	OC	OC	OC	OC
LAWSON, RUBY	D	H					D
JONES, BRINDA	D	H					D
THOMPSON, W. BURKE	D	H					D
HARRIS, MICHAEL	D	H	6a-230p (cc/prep)				D
<b>7:30am – 4:00pm</b>							
COLE, DAMON (PSA)	D	H					D
<b>12:00N – 8:30pm</b>							
TIDWELL, CATINA (CENSITRAC/PREP)	D	H					D
HOWELL, JOE	D	H					D
BRAZIL, MIKE	D	H					D
KIRBY, RALPH	D	H/OC	OC	OC	OC	OC	OC
BROWN, ANTYON	D	H					D

ORIENT – O  
ON CALL – OC

CASE CART – CC  
PLANNED ANNUAL LEAVE – PAL  
PLANNED SICK LEAVE - PSL

Certified Correct  
Posted

*4/28/12*

# DECONTAM SCHEDULE

Date: May 29- June 4

EMPLOYEE NAME	SUN	MON	TUES	WED	THUR	FRI	SAT
<b>7:00AM – 3:30PM</b>	29	30	31	1	2	3	4
PETERSON, STACEY	D	H					D
NETTLE, JOYCELYN (AGENCY)	D	H					D
RUSSEL, SHENELDER	D	H					D
GUNTER, JOE ANN	D	H					D
<b>8:00AM – 4:30PM ENT/EYE</b>							
JONES, D'ANDRE	D	H					D
SCOTT, WILLIAM	D	H					D
<b>8:00AM – 4:30PM 4<sup>TH</sup> FL</b>							
HENRY, BELINDA	D	H					D
SYLVESTER, FRANSHA (AGENCY)	D	H					D
<b>8:00AM – 4:30PM GI</b>							
COOK, GERALD (AGENCY)	D	H					D
FISHER, BERTHA	D	H					D
<b>10:00AM -6:30PM</b>							
COLLINS, GERARD	D	H					D
	D						D
<b>12:00N – 8:30pm</b>							
BROWN, JOHN	D	H					D
WATKINS, GINNY	D	H					D
<b>3:30P-12M</b>							
THOMPSON, HARRY	D	H					D
CARTER, MAURICE (DETAILED)	D	H					D
BRADLEY, JANICE (ML)	D	H					D

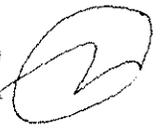
ORIENT – O

PLANNED ANNUAL LEAVE –PAL

PLANNED SICK LEAVE -PSL

Certified Correct

Posted

4/28/11 

# PREP/ADMIN SCHEDULE

Date: June 5-11

EMPLOYEE NAME	SUN	MON	TUES	WED	THUR	FRI	SAT
<b>6:00am – 2:30pm</b>	5	6	7	8	9	10	11
EVANS, PHILLIP (CC)	D						D
MANNING, REGINA (CC)	D						D
<b>10:00am – 6:30pm</b>	D						D
YAWN, JOE (CC)							
<b>7:00am-3:30pm</b>							
ACOSTA, CARLA (ASST. CHIEF)	D						D
SIMON, JOAN (EDUCATOR)	D						D
HARRIS, LYNN (LEAD/CC)	D						
JOHNSON, DIANN	OC						D
LAWSON, RUBY	D						D
BROWN, ANTYON	D			PAL			D
THOMPSON, W. BURKE	D						D
JONES, BRINDA	D	OC	OC	OC	OC	OC	OC
GUNTER, JOE ANN	D						D
<b>7:30am – 4:00pm</b>							
COLE, DAMON (PSA)	D						D
<b>12:00N – 8:30pm</b>							
KIRBY, RALPH	OC						
HOWELL, JOE	D	OC	OC	OC	OC	OC	OC
BRAZIL, MIKE	D						D
HARRIS, MICHAEL	D						D
TIDWELL, CATINA (CENSITRAC/PREP)	D						D

ORIENT – O  
ON CALL – OC

CASE CART – CC  
PLANNED ANNUAL LEAVE – PAL  
PLANNED SICK LEAVE - PSL

Certified Correct  
Posted

*4/28/11*

## DECONTAM SCHEDULE

Date: June5-11

EMPLOYEE NAME	SUN	MON	TUES	WED	THUR	FRI	SAT
<b>7:00AM - 3:30PM</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>	<b>11</b>
PETERSON, STACEY	D						D
RUSSEL, SHENELDER	D						D
NETTLE, JOYCELYN (AGENCY)	D						D
<b>8:00AM - 4:30PM ENT/EYE</b>							
JONES, D'ANDRE	D						D
SCOTT, WILLIAM	D						D
<b>8:00AM - 4:30PM 4<sup>TH</sup> FL</b>							
HENRY, BELINDA	D						D
SYLVESTER, FRANSHA (AGENCY)	D						D
<b>8:00AM - 4:30PM GI</b>							
COOK, GERALD (AGENCY)	D						D
COLLINS, GERARD	D						D
<b>10:00AM -6:30PM</b>							
FISHER, BERTHA	D	PAL	PAL	PAL	PAL	PAL	D
<b>12:00N - 8:30pm</b>							
BROWN, JOHN	D						D
WATKINS, GINNY	D						D
<b>3:30P-12M</b>							
THOMPSON, HARRY	D						D
CARTER, MAURICE (DETAILED)	D						D
BRADLEY, JANICE (ML)	D						D

ORIENT - O

PLANNED ANNUAL LEAVE -PAL

PLANNED SICK LEAVE -PSL

Certified Correct

Posted

4/28/11

Thursday, 1/28/10

1300

You state all should wear the proper PPE in your work areas.  
As of tomorrow, all should wear plain clothes in SPD, then change clothes  
before reporting to work area.

We are working re-published Hazard instruments out, and all will  
then for  
(Make sure everyone checks their out date weekly  
(Daily rounds all to be made ensuring everything is clear in December  
and prep  
(The people are coming <sup>out</sup> ~~into~~ work to name the link in December.

(There are communication books to be kept new in case someone is  
out  
(G.U. has their own cyberspace in which we will clear

(The police has passed out information regarding safety at the V.A. Please  
read and sign.

(For those attending the in-service at the University, please bring \$20.00  
and camp time will be given to those who attend.

(The service will start again on Wednesday, 2/3/10

(There will be a re-published cover given in May for those going to election  
training.

(3) There is a survey going around about the job. Please complete it.

(4) There was an extra round out about today without an up angled  
00 count. Please put sets up correctly.

(5) There was a ceremony done Tuesday that there was a certain instrument  
that was made (a heavy pair of straight putaway screws). Please make sure  
you receive and jump on the set.

(6) Come down to please bear the instruments to see how far we're come  
A minor instrument will now be in 3 bags. Labelled 1, 2 & 3

- 1 The endoscopy set came back up and was said the inside of one of suction tips was dirty. It looks like dried rust, but surgery says it is blood. Please make sure all of your suction tips are clean and brushed out.
- 2 There is still a problem with people not labeling the sets correctly. Please write out on your tape what the set is before you wrap it.
- 3 Dr. Veck had to use three (3) laparoscopic sets to do a case. One didn't have a manly on it, One it was broken and the third is a locking Manly. Please make sure all of your sets are complete before you send them down.
- 4 There is a possibility we will be sterilizing suction catheters for the lab to put on their scopes. Be on the look out for them.
- 5 Some of the podiatry trays have been put up incorrectly. The Beaver Lake handles have not had their screws out of them and they were missing the various items.
- 6 There are two (2) new positions on the board for decontam and the prep room. They will hire within the VA system. People with experience.
- 7 Thanks to Phillip for re-arranging the GU cart.
- 8 One of the washers in decontam is constantly out of order. Johnny has been paged to come have a look at it.

- \* Decontam approached about trying to get sets in order before sending into prep area for processing. They are doing a good job.
- \* We now have diamondized knives for eye surgery that are not to be totally submerged in cleaning solution.
- \* Staff is continuously placing sterile items in the wrong place. It is hard to locate the items if they are mis-placed. Also, mis-labeled items.
- \* There has been a new CO<sub>2</sub> insufflation tubing introduced for the new laparoscopic rooms they are designing, as well as new light handles for room 6. There are new 1188 cameras introduced for both the laparoscopic and arthroscopy procedures.
- \* Dr. Sidman has new dilators that he will be using on his OCNL procedures. They will be located on the bottom of the GU cart.
- \* There are new 2.8 pediatric defibrillators in stock, as well as 4.8, 6.0 and 7.5 sizes.
- \* There are new right angle blades to the prostatectomy sets.
- \* There seems to be an over-supply of GI stapling devices and that they will not use and request us to send our stock to them. There is a laparoscopic and vascular cart now set up down stairs.

GENERAL PURPOSE TRAINING RECORD

Check if applicable: HPDM

PI/CQI

Patient Safety

Station 586 - VAMC, Jackson, MS

Title of Course: Unit Staff Meeting #1

Classroom Hours Credit: \_\_\_\_\_

Date: 1-28-10 Time: 1300

Location: SFD Conference Room

Training Presented To: \_\_\_\_\_

Sponsoring Service\*: \_\_\_\_\_

Instructor or Service Contact: Joceli Simms

\*Send sheet to sponsoring service for input into TEMPO/LMS

ID	LAST NAME (Print your name as it appears on your pay slip.)	FIRST NAME (Print your first name as it appears on your birth certificate.)	DOB (2 digits month/day)		SERVICE	T&L UNIT	POSITION	SIGNATURE
1	Peterson	Stacy	1	2	13	NS MST	MST	Stacy Peterson
2	WATKINS	Gina	7	8	64	NSG	NA	L. Watkins
3	Jones	Brinda	7	3	68	NSG	MST	Brinda Jones
4	Kelley	Gloria	0	4	23	NSG	Chief, SFD Intern	Gloria Kelley
5	Scott	William	0	8	30	NSG	MST	William Scott
6	Granderson	Cynthia	0	5	09	NSG		Cynthia Granderson
7	Howell	Joe	0	6	29	NSG	CRMST	Joe Howell, CRMST
8	Mangum	Yvette	1	1	10	NSG	MST	Yvette Mangum
9	SPRINGMANS	BESSIE	2	6	88	NSG	CRMST	Bessie Springmans
10	Smith	Belinda	8	8	37	NSG	CRMST	Belinda Smith
11	Tidwell	Cotney	0	8	13	NSG	MST	Cotney Tidwell
12	Johnson	Diann	0	7	29	NSG	MST	Diann Johnson
13	THOMPSON	BURKE	0	9	72	Nursing	C.S.T.	Burke Thompson
14	EDWARDS	Holly	0	8	31	Nursing		Holly Edwards
15	JOHNSON	Catherine	5	6	87	Nursing/SFD	Supr CST	Catherine Johnson



## COMPETENCY ASSESSMENT CHECKLIST

**TITLE: COMPETENCY FOR THE CLEANING AND DISINFECTION OF SURGICAL INSTRUMENTS WITHOUT LUMENS, PORTS AND CHANNELS**

Employee Name/Title \_\_\_\_\_  
 Department/Date \_\_\_\_\_  
 Supervisor/Trainer \_\_\_\_\_

ORIENTATION  
ASSESSMENT ( )

REGULAR ANNUAL  
ASSESSMENT ( )

**RATING CODE / METHOD: DO=DIRECT OBSERVATION**

A= No experience  
 B= Little experience; needs assistance  
 C= Competent to perform independently  
 D= Competent, performs independently, able to assess the competency of others

SPECIAL ASSESSMENT( )

SKILL EVALUATION	COMPLIANT WITH POLICY	RATING CODE	CORRECTION PLAN	VALIDATOR INITIALS
<b>PERSONAL PROTECTIVE EQUIPMENT, PPE</b>				
1. Donn PPE which consists of the following: (a) approved head and hair covering (b) long cuffed rubber/vinyl decontamination gloves (not surgical gloves) (c) impervious gown (long sleeved; fluid-impervious from elbows to cuff and from neck to bottom of gown; and length will be below knee. (d) impervious shoe covers (not paper shoe covers) (e) face shields (cover from ear lobe to ear lobe and below the chin). If a face shield is not utilized, safety glasses/goggles will be worn with a surgical face mask.				
<b>MANUAL CLEANING</b>				
1. Instruments received in SPD directly from OR in a closed container via the Dirty Dumbwaiter.				
2. Instruments sets removed from the case cart.				
3. Sorts instruments, removing delicate from heavy.				
4. Inspect and open or disassemble instruments and place in tray for processing.				
5. Watches for scalpel blades still attached to knife handles.				
6. Places scissors in the open position.				
7. Instruments with box locks are left in an open position.				

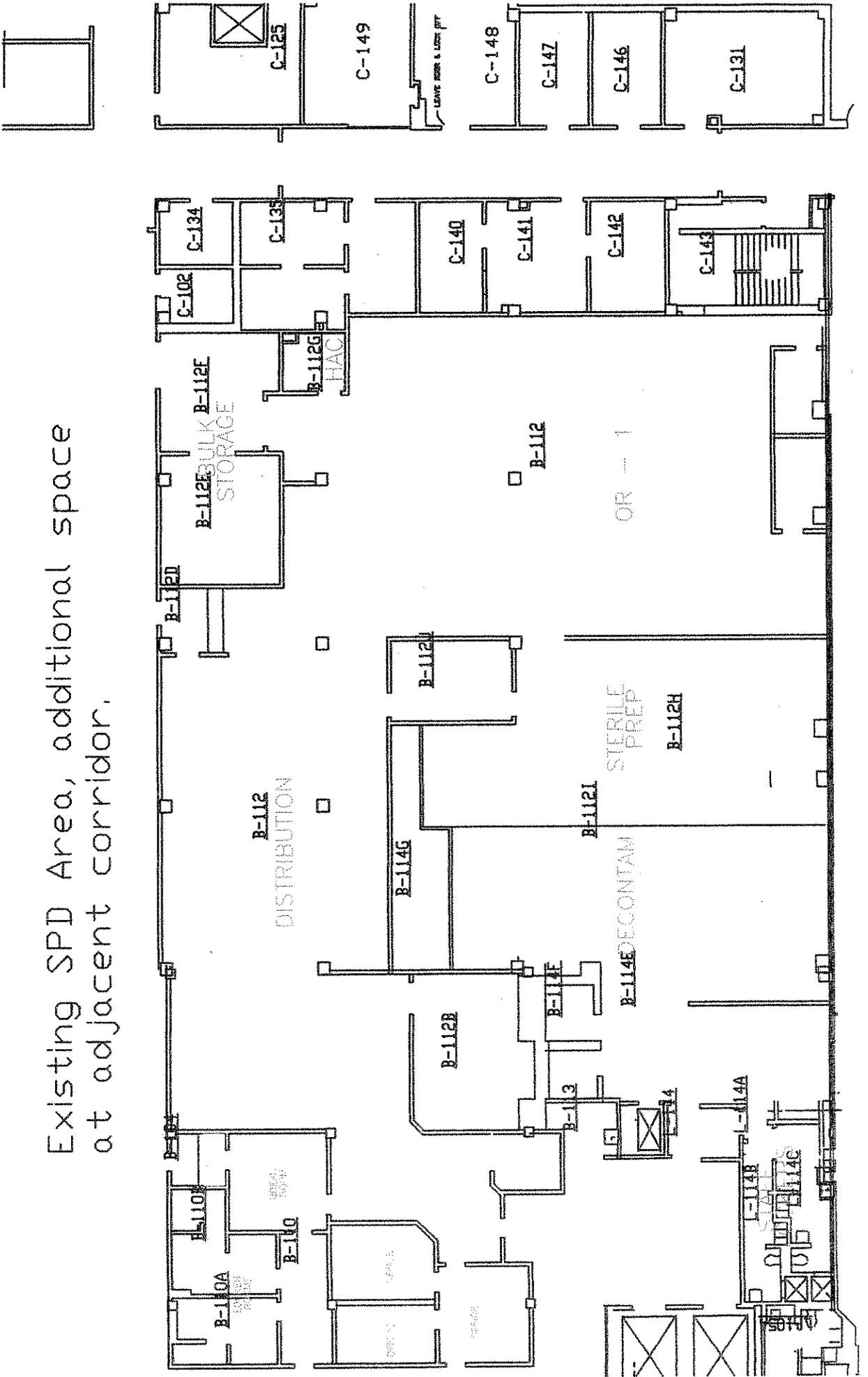
8. Multi-piece retractors, staplers, etc., disassembled are prior to cleaning.				
9. Traumatic towel clips are closed.				
10. Surfaces that have obvious debris are scrubbed using a soft bristled brush.				
<b>ULTRASONIC CLEANING</b>				
1. Insert the "Six position Terminal Block" into its retaining clip. Slide the clip over the rear or side wall of basket. The terminal block should now hang inside the basket.				
2. Attach the "Instrument Support Rack" to the instrument basket front wall with tips lying at a downward angle for drainage.				
3. Loads basket				
4. Inserts the instrument flush tubes into the terminal block using the quick disconnect side of the tubes.				
5. Inserts the larger main tube into the large end of the terminal block.				
6. Places instruments into basket.				
7. Connects the leur-lock fitting end of the small flexible tubes to the instruments connecting port.				
8. The instrument point is angled downward resting on bottom of basket.				
9. Ensures that the lumen of each device is in the open position.				
10. Ensures instruments are securely connected and positioned, the instruments are ready to process.				
11. Position the basket onto the automatic work tray elevator platform.				
12. Insert the large terminal black tube into the quick connect fitting located at the inside of the lid.				
13. Energize the footswitch to begin ultrasonic washer.				
14. Once cycle is complete, the lift platform is raised automatically. Instruments are carefully disconnected and remove.				
15.. Rinses the surgical instruments.				
16. Processes instruments through the washer/disinfector.				
17. Items not be processed through the washer/sterilizer are rinsed and patted dry with an absorbent material so that no water is left standing on the instruments.				

I have been provided and read a copy of the Standard operating procedure that covers this competency.	Date
Signature: _____	_____

Employee Signature: \_\_\_\_\_ Supervisor/Trainer Signature: \_\_\_\_\_



Existing SPD Area, additional space  
at adjacent corridor.



**G.V.(Sonny) Montgomery VAMC**  
**Jackson, MS**  
**PIRs Related to RME**

Date of Incident	Service	Brief Description	Point of Contact	Follow Up Action
12/6/2010	Surgery	PIR submitted on 12/6/2010 regarding a case being canceled due to a supply item not being available.	Joan Simon Charles Clark	This incident was a result of miscommunication. A "Wall" stent was listed as a special request on the preference card for the case. A note was made on the request form that the supply item was located in Interventional Radiology (IR), however this item was not the specific item requested by the physician. In an attempt to get the desired item, the Head Nurse OR asked sterile prep personnel, "How do we order this equipment?" in which he was informed that the item was carried by SPD. SPD personnel was not asked if SPD had the item. As of Dec. 8, 2010, SPD will stock this item and distribute this item to the OR. Notes on preference cards of items being located in other departments will cease. This item will be discussed in the SPD staff meeting and documented in the SPD Communication book.
11/10/2010	Surgery	PIR submitted on 11/10/2010 for an incomplete cataract set on instruments for a scheduled procedure which caused a significant delay.	Charles Clark Joan Simon	An irrigation cannula and cornea scissors were misplaced from the eye set. The cornea scissors were in a mislabeled peel pack on the set. The irrigation cannula was not included. With the patient on the table, it would have taken 45 mins to sterilize the cannula in SPD. The cannula was sent to OR for flash sterilization. The case was delayed for a total of 24 mins. The staff member responsible was counseled by Assistant Chief SPD. A staff supervisor reviewed the pull sheet for the eye instrument set (9 pieces) with staff in sterile prep. The staff member responsible had never made an incorrect instrument placement on a set.
10/4/2010	Surgery	A dirty burr was detected on the inside of a Hand tray resulting in the case being aborted and the patient rescheduled.	Charles Clark Joan Simon	An inservice for Medical Supply techs for Sterile Prep and Decontamination was conducted on 10/7/2010 on Procedure for Cleaning/Inspecting instruments arriving in Decontamination and Prep. The case is being reviewed by Nursing Administration. Further action pending the review.

**G.V.(Sonny) Montgomery VAMC  
Jackson, MS  
PIRs Related to RME**

Date of Incident	Service	Brief Description	Point of Contact	Follow Up Action
8/16/2010	Podiatry	Sterile instrument opened in the Podiatry Clinic and found to have what "looked like dry blood in the hinge area of the instrument."	Joan Simon	Daily and weekly rounds are made through Podiatry by the Acting Chief SPD and QM Specialist, respectively, to address any concerns or issues. The Podiatry nippers are inspected and hand delivered daily by the Acting Chief SPD. This is reported daily in morning meeting and monitored through the SPD Reprocessing Daily Report. Podiatry is also a standing monitor in the monthly SPD/RME Oversight Committee meeting, and the Podiatrist is a member of the same, to report any additional needs or concerns. The nippers were pulled from circulation due to the stains from sterilization of time. New nippers (10) have been ordered and received. These nippers were placed into circulation as of August 31, 2010. Fact Finding completed. - Closed.
6/30/2010	Podiatry	Dried blood on blades of blunt Westcott scissors at hinge	Joan Simon	Response pending.
1/27/2010	OR	The 5mm 45 Degree Angle Telescope Lens from the Laparoscopic instrument tray did not return from the OR. The OR charge nurse and OR staff were unable to locate item.	Joan Simon	The OR Staff (circulating nurse and OR tech) will check trays for missing instruments prior to returning case carts to SPD.

**G.V.(Sonny) Montgomery VAMC  
Jackson, MS  
PIRs Related to RME**

Date of Incident	Service	Brief Description	Point of Contact	Follow Up Action
1/14/2010	OR	The Stryker System Six Drill returned to SPD from the OR. It was noted that the Hudson Modified Trinkle Attachment was missing. It could not be located by OR staff.	Joan Simon	The circulatory nurse and scrub tech will ensure that all instruments are present and accounted before sending case cart to SPD.
12/4/2009	OR	HD Lens pan mislabeled Ortho Lens and Cord on the outer sterile tane	Lynn Harris	Prep Staff retrained on HD Lens Pan and labeling tape before wrapping any instrument set or pan.
11/26/2009	OR	Laminectomy set did not have required instruments.	Lynn Harris	Instruments not included were on back order when case was scheduled. Provider scheduled procedures after being informed that the some of the instruments for that procedure were on back order.
11/25/2009	Podiatry	Notified by Dr. Yeager of soiled podiatry instruments.	Dr. Yeager	Podiatry was visited by QM Chief, QM Specialist, and SPD Chief to analyze the instruments. The Hydrogen peroxide poured on the suspected area of the instrument did not react. Weekly monitoring of Podiatry area and instruments by SPD and QM Specialist.
11/24/2009	OR	Midas Rex Drill pan appeared to have a rustic/brown spot inside the container or pan that houses the drill.	Lynn Harris	Decontamination/Prep Staff made aware to check the inside of the Pans (instrument cases) after each cycle before wrapping for sterilization during a weekly update/training session.

G.V.(Sonny) Montgomery VAMC  
 Jackson, MS  
 PIRs Related to RME

*No administrative action taken against anyone in either Decontamination or Preparation Area.*

Date of Incident	Service	Brief Description	Point of Contact	Follow Up Action
11/17/2009	OR	Soiled stylet inside a Furlow found before the start of the case.	Lynn Harris Sandra Dunklin	Decontamination staff retrained on instrumentation.
11/6/2009	Podiatry	Blood, dirt, and tissue on nippers reported by Dr. Yeager.	Dr. Yeager	Housekeeping closet in Podiatry was converted to a pre-cleaning room for podiatry instruments. All staff trained on pre-cleaning podiatry instruments. Daily monitoring of Podiatry instruments by SPD (officially documented as starting Jan 11 2010) and Weekly rounds by QM Specialist.
10/16/2009	OR	Suction tubing in ENT tray in OR case was grossly soiled when the sterile tray was opened.	Dr. Franzese	Fact Finding Completed - Closed.

*Administrative action taken against Bruce Spriggs, Preparation area.*

G.V. (Sonny) Montgomery VA Medical Center

SPD/RME Oversight Committee Agenda

June 10, 2010

Surgical Service Conference Room

CONFIDENTIAL DOCUMENTS

38 U.S.C. 5705 & Implementing Regulations

QM Activity: \_\_\_\_\_

Present:

Quality of Care  
Access to Care  
Customer Service  
Maximize Resources  
Building Healthy Communities  
Employer of Choice

AGENDA ITEMS						DISCUSSION/ CONCLUSIONS	RECOMMENDATIONS/	RESPONSIBLE	TARGET DATE/
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Approval of Minutes:

OLD BUSINESS:

1. Update by FMS Renovation and Request for Updated SPD (possible project call for renovation of SPD)	X			X		Associate Director/Patient Care Services will get an update from Chief FMS.	QM Specialist to follow-up with FMS and Associate Director/Patient Care Services.	QM Specialist	Pending June 10, 2010
2. ETO Sterilizer Update	X	X		X		The new ETO sterilizers are in place in SPD, but not operational (waiting on duct work to be completed). Current ETO sterilizer still in operation until installation and in-service are complete. Designated day of in-service is June 1, 2010.	Continue to monitor until installation and in-service is complete.	Chief, SPD	Pending June 10, 2010
4. Primary-Care Pre-Cleaning	X				X	Training of Primary-Care staff on pre-cleaning has continued every Friday. Low Extremity NP stated that this training was complete for all primary-care staff that would be rotating through podiatry in case of podiatry/lower extremity staff absence.	Verification, final count, and percentage of staff trained to be updated at next meeting.	QM Specialist	Pending June 10, 2010
6. SPD update on new Staff	X				X	Chief, SPD announcement closed one month ago. No announcement or selection made. 3 new staff was proposed. 3 staff selected. 2 of them have completed employee physicals with one pending. Assistant Chief, SPD selection has been made and the candidate is currently in training.	Will continue to monitor and update.	Chief, SPD	Pending June 10, 2010
7. Instruments ready to be distributed to Primary Care Clinics	X				X	NP, Lower Extremity Clinic explained that the primary care clinics will be clipping their respective patients' toe nails. These patient will not be referred to lower extremity for the clipping of nails. New nippers have been ordered and received by Chief SPD. There was concern of how each clinic would be able to keep track of their own nippers after being sent to SPD for sterilization. SPD Chief stated that she will inform NP, Lower Extremity Clinic when SPD is ready to begin marking the nippers according to each clinic. Nippers will be marked with color coded tape.	Will continue to monitor until nippers are marked and distributed to each clinic.	Chief, SPD NP, Lower Extremity Clinic	Pending June 10, 2010
8. VISN 7 RME Website Status Report						Per Center Director's request, (VISN-7 QMO) has been contacted regarding VISN 7's method for monitoring RME's. Awaiting response. The current Executive Rounding checklist reflects this website (used as an example to construct checklist). The checklist is modified based on area to be toured.	Will report to committee after receiving response from VISN 7 QMO.	QM Specialist	Pending June 10, 2010

**G.V. (Sonny) Montgomery VA Medical Center**

SPD/RME Oversight Committee Minutes

August 27, 2009

Surgical Service Conference Room

**CONFIDENTIAL DOCUMENTS**

38 U.S.C. 5705 & Implementing Regulations

QM Activity: \_\_\_\_\_

**Present:** Ava Abney, Marsha Arnold, Joe Vaughn, Larry Lyons, Johnny Smith, , Emily Spruill, Edward Yankowski, Tammi Culberson, Paul Lirette, Mike Palmer, Joan Simon, Edward Yankowski,

**Absent:** Ann Demrow, Phyllis Johnson, Licinda Collins, Don Wainwright, Latoya Readus, Julie Robbins, Christine Franzese, Dorothy White-Taylor, Carolyn Tindall, Dr. Liep Tjeng, Latoya Johnson-Hood, Risa Webb, Dr. Zurab Guruli,

**Guests:**

AGENDA ITEMS	DISCUSSION/ CONCLUSIONS	RECOMMENDATIONS/ ACTIONS	RESPONSIBLE PARTY	TARGET DATE/ STATUS/ EFFECTIVENESS
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**OLD BUSINESS:**

**Approval of July 29, 2009 minutes:**

Update on status of completion of non-critical RME lists, SOPs, etc. for all Services.	Request was sent to all Services under the Center Director's signature, for a list of all non-critical RMEs.	Lists have been received from several services, but none has been submitted from any of the Specialist clinics.	Acting Chief, SPD	Pending
Renovation and Request for Updated SPD	Possible project call for renovation of SPD	No report. Deferred until next meeting.	Chief, FMS	Pending
Presentation of Dental Service SOP for Non-Critical Instruments/ Equipment	Procedure was approved by Committee and signed.	No action required.	Infection Control Nurse/Hospital Epidemiologist	Closed
Revisions to Draft Functional Statement for Committee utilizing RME Directive Language	There was discussion concerning the contents of the functional statement for this committee. Members believe that most of the information covered is already being reported in other Committees (OR and Infection Control).	Members requested that this Committee be disbanded as most of the information covered by the Functional Statement is reported at OR and Infection Control Committee. We may need a small workgroup of staff who will be working on RME for the facility. Asst. Chief, QM will investigate this possibility.	Asst. Chief, QM	Pending

SPD 6 mth. Evaluation:	<p>Infection Control Nurse reported repeat finding from the 6 month SPD Evaluation. Repeat items include:</p> <ol style="list-style-type: none"> <li>1. Education of staff (Not all SPD staff have completed training). On the Distribution side, 6 staff failed and 1 is to go to training in August. On the Sterile Prep side, 4 staff failed the test, 4 are certified, 4 need to have the training, and 4 have allowed their certification to expire. There is a problem with this because it is recommended but not mandated that SPD staff be certified. Acting Chief, SPD has completed the Level I Cluster training.</li> <li>2. Open cases of supplies were found in the Bulk storage area.</li> <li>3. Out of stock and expired items were found. (Out of stock items have decreased from last review, but expired items increased)</li> </ol>	<p>There was discussion as to how the accountability of the staff responsible for outdates, out of stock, and open cases is handled. Committee recommended that Union Representatives be invited to the next meeting. Action plans in response to the open cases, out of stock, and expired items should be submitted at the next meeting by the Acting Chief, SPD</p>	Infection Control Nurse/Hospital Epidemiologist/Acting Chief, SPD	Pending
<b>NEW BUSINESS:</b>				
Information Item from VISN concerning incidents with RME at other facilities	<p>There was discussion of the various incidents at other facilities concerning RME. Items include: India Ink sterilized at MDs home, fiber optic intubation device purchased by Anesthesiologist (who did not report purchase to facility) was not being reprocessed by facility staff, Speech Pathologist using stroboscopes without policies, procedures, or competencies put in place, and a veteran was intubated using a physician's personally owned RME (which was carried in and out of the facility in the physician's personal bag).</p>	Services should forward information to their staff to ensure these practices are not being carried out at our facility.	All members	Closed

## **Kelley, Gloria A. (VHAJAC)**

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Thursday, July 09, 2009 8:05 AM  
**To:** Harris, Martha L. (VHAJAC)  
**Subject:** FW: Stryker C-8 and U-500 ETO Sterilization Parameters  
**Attachments:** c-8 flexible cystonephroscope steralization.pdf; U-500 Flexible Ureteroscope sterilization.pdf

Good Morning Lynn,

Per our discussion FYI

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, July 07, 2009 8:19 AM  
**To:** White-Taylor, Dorothy M. (VHAJAC)  
**Cc:** Kirsh, Leola R. (VHAJAC)  
**Subject:** FW: Stryker C-8 and U-500 ETO Sterilization Parameters

Dr. Taylor,

FYI, per Ms. Kirsh

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Monday, July 06, 2009 6:41 PM  
**To:** Kirsh, Leola R. (VHAJAC)  
**Cc:** Kelley, Gloria A. (VHAJAC)  
**Subject:** FW: Stryker C-8 and U-500 ETO Sterilization Parameters

Hello Ms. Kirsh,

Per our earlier conversation, Anderson Products maintains that their EOGas Series 3+ Sterilizer is compatible with the endoscopes we have in use. It was further stated that the inert ingredient; 4%/10% of the 96%/90% EtO mixture, is a solid substance which keeps the liquid stabilized until it hits the air and prevents it from catching fire and exploding. The percentages are based on the inactive gas mixture while in the liquid state however, once the mixture becomes a gas, it becomes 100% EtO. I discussed the sterilization parameters with Margaret Garibay and they are as she stated as follows: Temperature 50± 2C°, Relative Humidity: 35%, EtO Concentration: 11 grams per # 6 bag/cartridge, 5 grams per #5 bag /cartridge. Additionally, nowhere in Anderson's instructional manual do any of these values appear which is questionable.

Based on the sterilization parameters provided below from Stryker, the EOGas Series 3+ parameters are incompatible with Stryker and therefore sterilization of our endoscopes is at risk of being grossly compromised. STORZ and Olympus endoscopes all have sterilization parameters similar to Stryker and incompatible to be sterilized using the Anderson EOGas Series 3+.

I'm still searching for additional information on Pentax and should have a definitive response for you by tomorrow.

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**From:** Chow, Alfred [<mailto:Alfred.Chow@stryker.com>]  
**Sent:** Monday, July 06, 2009 5:48 PM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Subject:** Stryker C-8 and U-500 ETO Sterilization Parameters

Gloria:

Per our conversation today, the sterilization procedures for the C-8 and the U-500 are as follows.

**C-8 and U-500**

Temperature:  $60 \pm 5^{\circ}\text{C}$  ( $131^{\circ}\text{F} \sim 149^{\circ}\text{F}$ )

ETO Concentration: 600 mg/L

Relative Humidity:  $75\% \pm 5\%$  RH

Vacuum: 2-3 psi

Exposure time: 120 minutes

Aeration Time: 4 hours

Aeration Temperature:  $45 \pm 5^{\circ}\text{C}$  ( $115 \pm 10^{\circ}\text{F}$ )

If these sterilization parameters are not followed, I can not guarantee the sterility of your scopes. I have attached the sterilization portions of the user manuals to this email, for your reference. Please feel free to contact me with any questions that you may have.

Alfred Chow

Technical Support Team Lead

Stryker Endoscopy

5900 Optical Court

San Jose, CA 95138

t: (408) 754-2484

c: (408) 533-5403

[alfred.chow@stryker.com](mailto:alfred.chow@stryker.com)

**Kelley, Gloria A. (VHAJAC)**

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Monday, July 20, 2009 11:40 AM  
**To:** Simon, Joan A. (VHAJAC); Harris, Martha L. (VHAJAC)  
**Cc:** Kelley, Gloria A. (VHAJAC)  
**Subject:** Stainless Steel Instruments  
**Attachments:** Duckworth & Kent Ltd.mht; Surgical Instruments.pdf; MastelReUseInstructions.pdf; Geuder, Reprocessing Manual.pdf

Hello Everyone,

Here are just a few of the vendors that I have reprocessing information on at this time.

*Gloria A. Kelley*

Chief, SPD Intern

G.V. (Sonny) Montgomery VA Medical Center

1500 East Woodrow Wilson Drive

Jackson, MS 39216-5199

Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440

Fax: (601) 368-4171

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**Kelley, Gloria A. (VHAJAC)**

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Wednesday, August 19, 2009 5:20 PM  
**To:** Vaughn, Joseph P (VHAJAC); Garner, Rosa T. (VHAJAC)  
**Cc:** White-Taylor, Dorothy M. (VHAJAC); Snell, Valerie E (VHAJAC); Kirsh, Leola R. (VHAJAC); Simon, Joan A. (VHAJAC)  
**Subject:** RE: Vendor Training for RME  
**Attachments:** Urgent Training Requirement Summary Sheet.xls

Hello Joe,

Per Mrs. Garner's request, attached you'll find a listing of SPD's most urgent training requirements. The columns highlighted in yellow are indicative of the most pressing training requirements which need to be satisfied as soon as possible. Any assistance that you can provide in expediting this process is greatly appreciated.

Thank you,

*Gloria A. Kelley*

Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
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**From:** Garner, Rosa T. (VHAJAC)  
**Sent:** Wednesday, August 19, 2009 7:53 AM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Cc:** Vaughn, Joseph P (VHAJAC); White-Taylor, Dorothy M. (VHAJAC); Snell, Valerie E (VHAJAC); Kirsh, Leola R. (VHAJAC); Simon, Joan A. (VHAJAC)  
**Subject:** Vendor Training for RME

Gloria,

Please send Joe Vaughn a list of the vendors and equipment where staff have not had vendor training.

*Director Geriatrics/Extended Care (118 C)  
G. V. (Sonny) Montgomery VAMC  
1500 E. Woodrow Wilson Drive  
Jackson, MS 39216*

*601-368-3861*

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**Kelley, Gloria A. (VHAJAC)**

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, August 25, 2009 7:59 AM  
**To:** Simon, Joan A. (VHAJAC)  
**Subject:** Welcome Back!

Good Morning Joan,

I hope that you enjoyed your vacation with your family. I know that you probably have a lot on your plate today after having been gone for about a week, but if you have the time this morning, I would like to come down to your office and go over the Endoscope books with you.

Thank you,

*Gloria A. Kelley*

Chief, SPD Intern

G.V. (Sonny) Montgomery VA Medical Center

1500 East Woodrow Wilson Drive

Jackson, MS 39216-5199

Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440

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**Kelley, Gloria A. (VHAJAC)**

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Saturday, August 29, 2009 10:16 PM  
**To:** Simon, Joan A. (VHAJAC)  
**Cc:** Kirsh, Leola R. (VHAJAC); White-Taylor, Dorothy M. (VHAJAC)  
**Subject:** Endoscope Inventory List  
**Attachments:** Project 1.xlsb

Good evening,

An Endoscope inventory was conducted to provide a comprehensive inventory accounting of the total number of endoscopes on-hand or in use at the G.V. Sonny Montgomery VA Medical Center. A preliminary review and subsequent inventory and analysis of eight (8) functional areas responsible for reprocessing endoscopes were performed. These areas included the following: OR, Anesthesiology-scope reprocessing responsibilities relocated to SPD, Respiratory,GI,GU, Cath Lab, ENT, and SPD.

In the attachment, there is an Endoscope Overview which provides a breakout of the endoscopes by office of primary responsibility (OPR) and a corresponding overall total number of endoscopes being reprocessed facility wide. In total, there are 89 endoscopes with 49 different models with the applicable manufacture's guidelines, SOP's, documented training, competencies performed, etc. being available. In addition, there are about 48 endoscopes without required documentation however, efforts to obtain the necessary documentation; manufacture's guidelines, are currently underway and corresponding SOP's will be developed thereafter. Essential personnel responsible for reprocessing these assets will be provided with the necessary training as well.

*Gloria A. Kelley*

Chief, SPD Intern

G.V. (Sonny) Montgomery VA Medical Center

1500 East Woodrow Wilson Drive

Jackson, MS 39216-5199

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## Kelley, Gloria A. (VHAJAC)

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, September 29, 2009 3:27 PM  
**To:** Simon, Joan A. (VHAJAC); Spruill, Emily E. (VHAJAC)  
**Subject:** FW: Cleaning verification information for VA Jackson MS  
**Attachments:** Automated Washer - Flow Chart activities only.pdf; Support for Cleaning Verification with the TOSI.pdf; Updated decontamination standards & guidelines 2009.pdf; Improving Cleaning Flexible Endo Kovach Humpfries.pdf; Support for Monitoring the Process of Cleaning Flexible Scopes.pdf; study on hemocheck and Endocheck.pdf; detail information on channlecheck method.pdf

Good Afternoon,

Here is the information per our discussion with Mr. Bryan White this morning.

*Gloria A. Kelley*

Gloria A. Kelley, CRMST  
Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
Fax: (601) 368-4171

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**From:** Stephen Kovach [mailto:cpdguy@healthmark.info]  
**Sent:** Tuesday, September 29, 2009 2:45 PM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Cc:** van@healthmark.info; 'Bryan White'; 'Steven J Basile (E-mail)'  
**Subject:** Cleaning verification information for VA Jackson MS

Hi Gloria,

My name is Stephen M. Kovach; I am the educator for Healthmark Industries.

Bryan white asked me to contact you and send you information on our TOSI and other cleaning verification products.

I will start with a general view on cleaning verification , then go into the TOSI and end up on flexible scope scopes.

Healthmark believes that monitoring the cleaning process should be part of every department's hospital quality improvement program. We have products that along with a quality improvement program allow the sterile processing professional to verify their cleaning process when using an automatic washer. I have attached a flow chart that outlines this process.

The T.O.S.I is the product that for the last ten years has been the industry standard for testing. Let me explain what the TOSI is and is not. The TOSI is comprised of components of blood. There is no secret ingredient that biases the TOSI toward one cleaning method or another.

The TOSI is comprised of hemoglobin, fibrin and albumin. Hemoglobin is the protein released from red blood cells. It is completely water soluble. Thus, no chemistry is needed to wash away this component of the test. Water alone will do it. If hemoglobin remains on the test after a wash cycle then it means one of two things occurred:

- 1) Poor mechanical action. In other words, water in sufficient volume did not reach the test. This could happen because of blocked spray arms, twisted spray arms, a bad coupling (so water does not get out to the arms) or a pump failure.
- 2) Hot water is used during the cold water pre-rinse. If this occurs, the heat water fixes or denatures the protein. At 110F, protein, including hemoglobin, is rapidly denatured and becomes highly water insoluble thus water alone will not wash it away.

Albumin is also water soluble and the same rules apply to albumin as the hemoglobin.

Fibrin is the coagulating agent in blood. When we get cut, it is the fibrin protein binds together to clot and block bleeding. Fibrin is highly water insoluble. On the TOSI test, it is the translucent layer. It is below the hemoglobin/albumin layer. Being water insoluble, chemical agents, enzymes or high alkaline detergents, are needed to break it down and render it water soluble. This occurs in a process called hydrolysis. Literally, this means the chemical agent alters the fibrin protein, rendering it water soluble. If the fibrin layer remains on the TOSI test it is indicative of any one of the following errors:

- 1) Proteolytic detergent (enzymatic or alkaline) did not reach the wash chamber, or did not reach the chamber in sufficient concentration to be effective.
- 2) Exposure time was insufficient. Detergents need time to interact with the insoluble proteins and break them down (hydrolyze) to be washed away. By observation, this time period should be for at least 5 minutes.
- 3) Incorrect temperature. Both enzymatic and alkaline detergents are sensitive to temperature. Enzymatic detergents work best in the range of 100 - 125F. Alkaline detergents work best at temperatures 150F and up. If the temperature is outside of the optimal range it will reduce the effectiveness and could even render the detergent completely ineffective.
- 4) Poor water quality. Detergents of any kind are sensitive to water quality - in particular to the water hardness and pH-level. If the water is exceptionally hard, or if the pH level is above or below the optimal range for the detergent, it will render it ineffective.

So you see the TOSI is not just a pass-fail test, but also is suggestive of the source of failure. We have also introduced a variety of other tests that can be run with the TOSI to help monitor key parameters of cleaning, (water temperature, water quality, proteolytic agents, etc.) and diagnose the source of failure.

The design of the TOSI reflects one of the most difficult areas of a surgical instrument to get clean the box lock area. This is the area as you well know is difficult to clean and hard for the CS professional to look at.

You want to challenge any automatic washer with a soil and test design that best reflects their practice. THE TOSI is such a product.

Using the TOSI is part of our Quality Improvement program which allows departments to improve their automatic cleaning process.

By implementing a QIP, you will be able to detect concerns before they become a larger problem.

The TOSI is the standard for cleaning verification for automatic washers. It follows the ASTM D277 guidelines (the only cleaning verification test on the market) and is outlined in the new AAMI ST 79 annex D.

I have put our link to our information on cleaning verification. You can download any of the supporting information from videos to peer reviewed articles.

<http://www.healthmark.info/TOSI.php>

Monitoring the cleaning process with **independent verification products** is now becoming the standard. Nancy Chobin has pointed this out in her article "The Value of Monitoring the Cleaning Process "...the processing area needs a reliable methodology that will monitor the effectiveness of the cleaning process similar to the products in use to monitor the effectiveness of various sterilization process...the TOSI™ tools clearly identified sub-optimal cleaning processes/practices. The results correlated well to the artificial controls used and identified the lack of parts of the process (e.g., enzymatic pre-soak, ultrasonic cleaning)..."

Please read the complete article by clicking on this link.

[http://www.iceinstitute.com/shopping/course\\_material/c\\_cleaning.html](http://www.iceinstitute.com/shopping/course_material/c_cleaning.html)

One very important thing to keep in mind is that FDA

(<http://www.artificialtestsoil.com/FDAreferencePage.htm>), AAMI and other regulatory bodies recommend that any simulated-use testing be done with a surrogate device that closely approximates the actual types of soils the instrument is to be exposed to in clinical use. Further, the surrogate device should be made of the same type of material as the instrument it represents. Well that is the TOSI: dried blood soil on a stainless coupon is directly analogous to dried blood on a stainless instrument. **It is the only test that can make these claims.**

Again, the TOSI is designed to be used in any washer with any type of cleaning solution. If it does not come clean, there are reasons and those reasons can be corrected. The TOSI is to help with the performance of any automatic washer, regardless of manufacture or type of cleaning solution is being used.

Concerning Flexible scopes; we have two products that allow you to verify your cleaning process. This first is the EndoCheck product line. This is a swab technique; where you swab the channel with a specific swab and then cut the tip off and place it in a reagent and a color change will tell you the result. These tests are specifically for hemoglobin and protein. We also offer the channel check

which is a flush method and it allows you to check for three soils at one time, I have attached information on both of these products.

Healthmark is the only company with comprehensive tests for cleaning verification tests to measure water temperature, water quality, cleaning efficiency, and directly test residual soil on instruments.

I have sample policies, competency and a CEU program for cleaning verification you can use, just ask me for them.

Healthmark looks forward to working with both of you and your staff on this project and others in the future.

In closing, Healthmark long standing philosophy on testing is now supported by both AORN and AAMI. AAMI and AORN are now recommending WEEKLY testing of instrument reprocessing equipment, including the washer-disinfector. These recommendations can be found in **AAMI ST 79 Section 7.5 and AORN Recommended Practices for Cleaning and Care of Surgical Instruments and Powered Equipment 2008**. Please note (AAMI ST 79 and AORN Recommended Practices for Cleaning and Care of Surgical Instruments and Powered Equipment are copyrighted documents of AAMI and AORN and as such, I cannot share duplicate copies of it, or even in writing quote extensively from it without AAMI or AORN permission. If you do not have copies I would suggest buying copies off of their web pages).

Gloria, I know I have given you a lot of information, if I can answer any questions, please do not hesitate to contact me or our local Healthmark representative who I have cc on this email.

When you receive this email could you please let me know you got it, thank you. I have been having some email concerns lately.

I know you have a choice when buying healthcare products. I want to thank you for looking at Healthmark products and please remember,

Take care, and.. "Always Keep it Clean ."

Stephen M. Kovach

Director of Education

Healthmark Industries

1-800-521-6224/Ext.6621

Fax- 1-586-774-6473

Check out the latest information concerning Sterile Processing at the following link.

<http://sterileprocessingnews.blogspot.com>

**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Wednesday, September 30, 2009 4:25 PM  
**To:** Simon, Joan A. (VHAJAC)  
**Subject:** DASHBOARD.xls  
**Attachments:** DASHBOARD.xls

Hello Joan,

Per our conversation

*Gloria A. Kelley*  
Gloria A. Kelley, CRMST  
Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
Fax: (601) 368-4171

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**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Friday, October 02, 2009 2:15 PM  
**To:** Simon, Joan A. (VHAJAC)  
**Subject:** Medivator DSD-201  
**Attachments:** Medivator DSD-201.doc

Hi Joan,

Here is the SOP on the Medivator that I had worked on for Billie.

Thank you and have a Great Weekend!

*Gloria A. Kelley*

Gloria A. Kelley, CRMST  
Chief, SPD Intern

G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199

Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440

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**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, October 20, 2009 9:43 AM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Subject:** Scope Summary, SPD.xls  
**Attachments:** Scope Summary, SPD.xls

Scope sum

**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Wednesday, October 14, 2009 10:24 AM  
**To:** Bruce, Lisa B. (VHAJAC)  
**Cc:** Kirsh, Leola R. (VHAJAC); White-Taylor, Dorothy M. (VHAJAC)  
**Subject:** Current Endoscope Manpower.xlsx  
**Attachments:** Current Endoscope Manpower.xlsx

Good Morning Lisa,

Here is the current listing of personnel reprocessing RME outside of SPD proper per our previous discussions.

*Gloria A. Kelley*

Gloria A. Kelley, CRMST  
Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
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**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, October 20, 2009 9:46 AM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Subject:** Outdates Expired Items, Clean Steril Storage.xls  
**Attachments:** Outdates Expired Items, Clean Steril Storage.xls

s

**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, October 20, 2009 7:15 PM  
**To:** Simon, Joan A. (VHAJAC)  
**Cc:** Kelley, Gloria A. (VHAJAC)  
**Subject:** Nursing-Patient Care Services RME Summary (SPD).xlsx  
**Attachments:** Nursing-Patient Care Services RME Summary (SPD).xlsx

Joan,

Here is the RME Device Summary.

Gloria

**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Wednesday, October 21, 2009 1:50 PM  
**To:** Simon, Joan A. (VHAJAC)  
**Subject:** Defibrillator Monitor  
**Attachments:** Defibrillator Monitor.doc

Joan,

Here is the SOP per our discussion.

*Gloria A. Kelley*

Gloria A. Kelley, CRMST  
Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
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**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Wednesday, October 28, 2009 11:51 AM  
**To:** Johnson, Catherine (VHAJAC)  
**Cc:** Harris, Martha L. (VHAJAC)  
**Subject:** FW: Information Item: WebCIMS 442132 Clarification of Organizational Responsibilities in SPD  
**Attachments:** Tuesday, October 27, 2009.pdf

Good Afternoon,

Here is the latest directive defining SPD oversight responsibilities. Please advise personnel as deemed necessary.

Thank you,

*Gloria A. Kelley*

Gloria A. Kelley, CRMST  
Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
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**From:** Watson, Linda F. (SES) (VHAJAC)  
**Sent:** Wednesday, October 28, 2009 10:47 AM  
**To:** Abney, Ava C. (VHAJAC)  
**Cc:** VHAJAC Pentad Leadership; VHAJAC RME (Reusable MED Equipment)  
**Subject:** Fw: Information Item: WebCIMS 442132 Clarification of Organizational Responsibilities in SPD

New information  
Pls review/action in appropriate meetings

---

**From:** Ponder, Margaret (V16)  
**To:** VISN 16 Center Directors  
**Cc:** VISN 16 QUADRAD; VISN 16 LPEC; VISN 16 SPD Chiefs; VISN 16 Program Managers; VISN 16 Executive Secretaries  
**Sent:** Wed Oct 28 10:20:06 2009  
**Subject:** Information Item: WebCIMS 442132 Clarification of Organizational Responsibilities in SPD

**Information Item**

**Executive Summary:** WebCIMS 442132, Clarification of Organizational Responsibilities Related to Sterile Processing and Distribution (SPD) and Processing Reusable Medical Equipment (RME) was released by the Deputy Under Secretary for Health for Operations and Management (DUSHOM) (10N). This WebCIMS attempts to delineate core functions between Nursing Service and Logistics Service as they pertain to SPD. In order to ensure that the intent of this WebCIMS is met by all VISN facilities, the VISN 16 SPD Board and Logistics Program Executive Council (LPEC) will review the document and determine appropriate implementation procedures to ensure compliance. On completion of these reviews, facilities will be provided further guidance on how to proceed with implementation.

**Questions:** Please contact Joseph Vaughn, Network Materiel Manager, 601-364-7948 or Cynthia Due, CLO, 601-364-7930.

## Kelley, Gloria A. (VHAJAC)

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Wednesday, October 28, 2009 6:34 PM  
**To:** Johnson, Catherine (VHAJAC); Harris, Martha L. (VHAJAC)  
**Subject:** FW: Orientation Checklist for New SPD Employee  
**Attachments:** ORIENTATION TO SPD VASDHS (3).doc; image001.png

Good Evening?

Here is something that I thought you all might need to know about.

### *Gloria A. Kelley*

Gloria A. Kelley, CRMST  
Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
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**From:** Baker, Mary J.  
**Sent:** Wednesday, October 28, 2009 1:33 PM  
**To:** Melvin-Pifer, Jennifer DURVAMC; Pristas, Laura; Lillebo, Daniel M; Haub, Theresa L. (MRN); Pennington, Glenn E.; VA Supply Processing & Distribution  
**Subject:** RE: Orientation Checklist for New SPD Employee

*This is the one Dawn Berthiaume developed in 2005. Still looks good and I will be tweeking it a bit this FY with more RME emphasis.*

*Mary J. Baker, RN, MSN, CNOR, CLNC, CRMST*  
Educator-Supply, Processing, and Distribution  
VA San Diego Healthcare System  
3350 La Jolla Village Drive  
San Diego, CA 92161  
858-552-8585 ext. 1080

**From:** Melvin-Pifer, Jennifer DURVAMC  
**Sent:** Wednesday, October 28, 2009 10:37 AM  
**To:** Pristas, Laura; Lillebo, Daniel M; Haub, Theresa L. (MRN); Pennington, Glenn E.; VA Supply Processing & Distribution  
**Subject:** RE:

Durham would like also. Perhaps send to the group?

Jennifer R. Melvin Pifer, MBA, BSN, RN  
SPD, Acting Chief  
Durham VA Medical Center  
508 Fulton Street  
Durham, North Carolina 27705

Telephone (919) 286-0411 ext. 6460  
VA Pager 775

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**From:** Pristas, Laura  
**Sent:** Wednesday, October 28, 2009 9:53 AM  
**To:** Lillebo, Daniel M; Haub, Theresa L. (MRN); Pennington, Glenn E.; VA Supply Processing & Distribution  
**Subject:** RE:

Wilkes-Barre, also. Thanks.

---

**From:** Lillebo, Daniel M  
**Sent:** Wednesday, October 28, 2009 9:49 AM  
**To:** Haub, Theresa L. (MRN); Pennington, Glenn E.; VA Supply Processing & Distribution  
**Subject:** RE:

El Paso would also like a copy

---

**From:** Haub, Theresa L. (MRN)  
**Sent:** Wednesday, October 28, 2009 7:02 AM  
**To:** Pennington, Glenn E.; VA Supply Processing & Distribution  
**Subject:** RE:

Would also like to have a copy. Thanks in advance.

---

**From:** Pennington, Glenn E.  
**Sent:** Wednesday, October 28, 2009 7:12 AM  
**To:** VA Supply Processing & Distribution  
**Subject:**

DOES ANY ONE HAVE A TRAINING CHECK LIST FOR NEW MEDICAL SUPPLY TECHS ?

If so please respond only to me.

Thank You..

Glenn E. Pennington  
Supply, Processing & Distribution  
PHILADELPHIA VA MEDICAL  
TEL: 215-823-4641

**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Friday, October 30, 2009 8:12 AM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Subject:** Urgent Training Requirement Summary Sheet.xls  
**Attachments:** Urgent Training Requirement Summary Sheet.xls

train

**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Friday, October 30, 2009 1:03 PM  
**To:** Mathena, Karen VHACIN  
**Cc:** Johnson, Catherine (VHAJAC); Harris, Martha L. (VHAJAC)  
**Subject:** Additions to the SPD email group

Good Afternoon Ms. Mathena,

Would you please add our SPD Supervisor; Catherine Johnson and Lead SPD Technician; Martha L. Harris to the SPD email group.

Thank you,

*Gloria A. Kelley*

Gloria A. Kelley, CRMST

Chief, SPD Intern

G.V. (Sonny) Montgomery VA Medical Center

1500 East Woodrow Wilson Drive

Jackson, MS 39216-5199

Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440

Fax: (601) 368-4171

**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, November 03, 2009 10:04 AM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Subject:** Rigid Esophagoscope 12015AA  
**Attachments:** Rigid Esophagoscope 12015AA.doc

sop

**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, November 03, 2009 1:14 PM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Subject:** Rigid Esophagoscope 12015AA (2)  
**Attachments:** Rigid Esophagoscope 12015AA (2).doc

sop

**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, November 03, 2009 1:14 PM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Subject:** SPD Staffing.xlsx  
**Attachments:** SPD Staffing.xlsx

staff

**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, November 03, 2009 1:15 PM  
**To:** 'glowchan@aol.com'; Kelley, Gloria A. (VHAJAC)  
**Subject:** SPD OJT-Training.xlsm  
**Attachments:** SPD OJT-Training.xlsm

Spd training

**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, November 03, 2009 4:33 PM  
**To:** Johnson, Catherine (VHAJAC)  
**Subject:** FW: SPD

Good Cat,

Here is the protocol on the transportation of clean/sterile supplies and instruments to the Dental Clinic's new location. Please disseminate to your personnel.

Thank you,

*Gloria A. Kelley*

Gloria A. Kelley, CRMST  
Chief, SPD intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
Fax: (601) 368-4171

---

**From:** Eldridge, Paula (VHAJAC)  
**Sent:** Tuesday, November 03, 2009 12:03 PM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Subject:** FW: SPD

THIS IS WHAT JOAN SENT TO ME!  
TO ADDRESS THE DIRTY/CLEAN ITEMS BEING TRANSPORTED AT THE SAME TIME.  
THEY HAD A TRUCK FIXED YESTERDAY WITH A DIVIDER SO THEY CAN TRANSPORT BOTH DIRTY/CLEAN  
IF YOU NEED ANY OTHER INFORMATION  
PLEASE LET ME KNOW!

*Paula B. Eldridge, CDA c/o*

---

**From:** Simon, Joan A. (VHAJAC)  
**Sent:** Tuesday, August 25, 2009 3:45 PM  
**To:** Eldridge, Paula (VHAJAC)  
**Cc:** Simon, Joan A. (VHAJAC)  
**Subject:** SPD

Paula, Here is SPD responsibility for Dental

1. All items to be cleaned and sterilized will be brought to Decontamination Area of SPD in a locked Red Bin
2. After items are Cleaned and sterilized dental trays will be placed in blue bins not to exceed 25 pounds and locked with a seal lock.
3. Items will be picked up from SPD for transport by transporter/driver.
4. Clean items will be picked up in SPD twice each day
5. Dirty items will be delivered to SPD twice each day.

**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Wednesday, November 04, 2009 10:37 AM  
**To:** Simon, Joan A. (VHAJAC)  
**Cc:** White-Taylor, Dorothy M. (VHAJAC); Garner, Rosa T. (VHAJAC); Kirsh, Leola R. (VHAJAC); Johnson, Catherine (VHAJAC); Harris, Martha L. (VHAJAC)  
**Subject:** Urgent Training Requirement Schedule for the Month of November.xlsm  
**Attachments:** Urgent Training Requirement Schedule for the Month of November.xlsm

Joan,

Attached is a copy of the vendor provided in-service training session I've scheduled thus far for the month of November 2009.

*Gloria A. Kelley*

Gloria A. Kelley, CRMST  
Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
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**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Monday, December 07, 2009 10:35 AM  
**To:** Simon, Joan A. (VHAJAC)  
**Cc:** White-Taylor, Dorothy M. (VHAJAC)  
**Subject:** SPD Training Schedule Checklist  
**Attachments:** SPD Training Schedule Checklist.doc

Good Morning Joan,

Attached is a copy of tasks that I should acquire while training in SPD. As I have stated to you in the past on numerous occasions, it is imperative that I be provided with this training without further delay.

Thank you,

*Gloria A. Kelley*

Gloria A. Kelley, CRMST  
Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
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**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Monday, November 16, 2009 1:25 PM  
**To:** Arnold, Marsha C (VHAJAC); White-Taylor, Dorothy M. (VHAJAC); Lyons, Larry J. (VHAJAC); Spruill, Emily E. (VHAJAC); Kirsh, Leola R. (VHAJAC)  
**Cc:** Bruce, Lisa B. (VHAJAC)  
**Subject:** RE: SCOPE REPROCESSORS

Hello Everyone,

This is the information that I've obtained thus far. In January 2009, STERIS reached an agreement with the U.S. Food and Drug Administration regarding the SYSTEM 1 Sterile Processing System. Effective January 20th, 2009, STERIS is selling the SYSTEM 1 processor in the U.S. on a "one for one" replacement basis only. STERIS will continue to support SYSTEM 1 for at least two years from the date of the notice with the sale of all accessories, STERIS 20 sterilant, service, parts and replacement units.

STERIS has submitted a 510(k) pre-market notification for an updated SYSTEM 1, which is currently under review by FDA. STERIS will work with our Customers on a timetable to transition to the purchase of a replacement.

*Gloria A. Kelley*

Gloria A. Kelley, CRMST  
Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
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**From:** Arnold, Marsha C (VHAJAC)  
**Sent:** Monday, November 16, 2009 10:56 AM  
**To:** White-Taylor, Dorothy M. (VHAJAC); Lyons, Larry J. (VHAJAC); Spruill, Emily E. (VHAJAC); Kirsh, Leola R. (VHAJAC); Kelley, Gloria A. (VHAJAC)  
**Cc:** Bruce, Lisa B. (VHAJAC)  
**Subject:** RE: SCOPE REPROCESSORS

Not me.

---

**From:** White-Taylor, Dorothy M. (VHAJAC)  
**Sent:** Sunday, November 15, 2009 8:36 AM  
**To:** Lyons, Larry J. (VHAJAC); Spruill, Emily E. (VHAJAC); Arnold, Marsha C (VHAJAC); Kirsh, Leola R. (VHAJAC); Kelley, Gloria A. (VHAJAC)  
**Cc:** White-Taylor, Dorothy M. (VHAJAC); Bruce, Lisa B. (VHAJAC)  
**Subject:** Fw: SCOPE REPROCESSORS

Has anyone heard anything about what this lady is saying about Steris One????????

D

-----  
Sent from my BlackBerry Wireless Handheld

---

**From:** Ferreria, Aurora  
**To:** Amick, Linda; Comtois, Janet; VHA GI Endoscopy Nursing  
**Sent:** Mon Nov 09 09:52:28 2009  
**Subject:** RE: SCOPE REPROCESSORS

FYI- Steris One machine is being phased out and will not be available until later (years?) – it has something to do w/ FDA compliance which is technical in nature.  
Two years ago, we bought a Steris Reliance EPS Endoscope Reprocessing System which does HLD for our EUS scopes that cannot go into Steris One. It can load 2 scopes at the same time. We've been very satisfied that we're replacing our 2 old Steris One with Steris Reliance for reprocessing any scopes.

---

**From:** Amick, Linda  
**Sent:** Monday, November 09, 2009 9:44 AM  
**To:** Comtois, Janet; VHA GI Endoscopy Nursing  
**Subject:** RE: SCOPE REPROCESSORS

We were told we had to use the Steris system here. Wanted Evotech.

---

**From:** Comtois, Janet  
**Sent:** Monday, November 09, 2009 10:42 AM  
**To:** VHA GI Endoscopy Nursing  
**Subject:** SCOPE REPROCESSORS

We are looking to replace our STERIS System one machines. I was wondering if you would tell me what machines you are using, what do you like best about them, can you process more than one scope at a time and if so, are the scopes next to each other or on top of each other. Thanks for the information.

Janet Comtois  
Same Day Surgery Nurse Manager  
Aleda E. Lutz VAMC

**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Monday, November 16, 2009 4:21 PM  
**To:** Simon, Joan A. (VHAJAC)  
**Cc:** White-Taylor, Dorothy M. (VHAJAC); Kirsh, Leola R. (VHAJAC)  
**Subject:** Rigid Esophagoscope 12015AA (2) (2)

Hello Joan,

Per our conversation, here is the SOP that you requested.

*Gloria A. Kelley*

Gloria A. Kelley, CRMST

Chief, SPD Intern

G.V. (Sonny) Montgomery VA Medical Center

1500 East Woodrow Wilson Drive

Jackson, MS 39216-5199

Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440

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**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Monday, November 16, 2009 4:21 PM  
**To:** Simon, Joan A. (VHAJAC)  
**Cc:** White-Taylor, Dorothy M. (VHAJAC); Kirsh, Leola R. (VHAJAC)  
**Subject:** Rigid Esophagoscope 12015AA (2) (2)  
**Attachments:** Rigid Esophagoscope 12015AA (2) (2).pdf

Hello Joan,

Per our conversation, here is the SOP that you requested.

*Gloria A. Kelley*

Gloria A. Kelley, CRMST

Chief, SPD Intern

G.V. (Sonny) Montgomery VA Medical Center

1500 East Woodrow Wilson Drive

Jackson, MS 39216-5199

Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440

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## **Kelley, Gloria A. (VHAJAC)**

---

**From:** Simon, Joan A. (VHAJAC)  
**Sent:** Friday, December 18, 2009 10:18 AM  
**To:** Johnson, Catherine (VHAJAC); Eldridge, Paula (VHAJAC); White-Taylor, Dorothy M. (VHAJAC); Kelley, Gloria A. (VHAJAC)  
**Cc:** Johnson, Catherine (VHAJAC); Harris, Martha L. (VHAJAC)  
**Subject:** RE: SPD Update

We may need to set up a meeting with dental and the employees transporting the instruments to pick up and deliver instruments twice a day. This process will decrease the number of instruments brought in at the end of the day and have the instruments process twice a day. At the end of the day is when we also have to process most of our surgical instruments.

---

**From:** Johnson, Catherine (VHAJAC)  
**Sent:** Thursday, December 17, 2009 5:41 PM  
**To:** Kelley, Gloria A. (VHAJAC); White-Taylor, Dorothy M. (VHAJAC)  
**Cc:** Simon, Joan A. (VHAJAC)  
**Subject:** RE: SPD Update

Dr. Taylor,

Upon arrival to duty Gloria and I met to discuss the Dental issues that occurred this morning, She informed me that she spoke with Diane not Lynn about not having enough containers to send all of dental's sterile instruments. I informed Gloria that we have never packaged 30 instruments in one single pouch at any given time. As for as not having enough dental exam kits and handpiece drills, We process and sterilize all of the instruments we retrieve from dental. I will speak to Joe tomorrow about the instruments that he has boxed up for dental. In order to make up more handpiece drills and exam kits. I have discussed with the staff about paying close attention to the number of containers that are being delivered by the drivers to ensure that we will have enough containers to send dental instruments back each morning. I suggested to Gloria we may need two drivers instead of one. One to deliver clean containers and the other one to deliver dirty instruments back to prevent cross contamination. This could be why the container are not being returned due to delivering contaminated items in the same vehicle. I was not aware of any instruments being in disarray. This could be due to transporting of the instruments in the van. We try to properly process and assemble instrumentation to be returned back to dental clinic for usage.

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Thursday, December 17, 2009 2:06 PM  
**To:** White-Taylor, Dorothy M. (VHAJAC)  
**Cc:** Johnson, Catherine (VHAJAC); Simon, Joan A. (VHAJAC)  
**Subject:** SPD Update

Good Afternoon Dr. Taylor,

Just to update you of today's events:

- 1) SPD only had 3 containers to place sterile instruments in for transportation to the Dental Clinic this morning. I called Paula Eldridge to determine her immediate needs. After speaking with Paula Eldridge regarding containers in Dental's possession as well as her requirements, she indicated that there was an unordinary number of blue containers; sterile supply transporters, remaining at the location. We discussed what items were critical to Dental having delivered to them in the a.m. run. She stated that they were completely out of Exam Kits and Hand Pieces and that it was critical that they have these items at a minimum. I asked Lynn and Diane if the containers earmarked to be transported to the Dental Clinic contained Exam Kits and/or Hand Pieces and Diane stated that none of the containers held those items. I then asked that the Exam Kits and Hand

Pieces be placed in those containers in lieu of what was contained in them before being transported to the Dental Clinic.

- 2) I had a meeting with Phil Poulin and discussed the dilemma the SPD had been faced with this morning regarding the lack of blue containers. He stated that he would have a discussion with all of his 4 drivers for ensuring that the blue containers are picked up from the Dental Clinic on a regular basis. I stated that we, SPD need to have a check and balance system in place to ensure that we also communicate our requirements to his office for additional containers when we reach a pre-determined safety level so that we won't run out.
- 3) Paula also expressed her concerns over receiving inadequate service from SPD. She mentioned never having enough Exam Kits being returned to the Dental Clinic, missing cavatron tips and endo clamps, instruments in disarray, receiving a single peel pouch with as many as 30 instruments placed inside, oral surgery instruments being placed in other trays, etc. I asked her to send it to us in writing so that we may adequately address all of her issues and improve our customer support to her service.
- 4) I met with Catherine Johnson this afternoon and briefed her on today's activities to discuss with SPD staff members.

*Gloria A. Kelley*

Gloria A. Kelley, CRMST

Chief, SPD Intern

G.V. (Sonny) Montgomery VA Medical Center

1500 East Woodrow Wilson Drive

Jackson, MS 39216-5199

Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440

Fax: (601) 368-4171

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**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, December 22, 2009 4:27 PM  
**To:** Johnson, Catherine (VHAJAC)  
**Subject:** Schedule.xls  
**Attachments:** Schedule.xls

Hello Cat,

Per our conversation,

Gloria

**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Friday, January 22, 2010 1:08 PM  
**To:** Smith, Johnny Lee (VHAJAC)  
**Subject:** Product Evaluation Respiratory First Step Pre-Clean  
**Attachments:** Product Evaluation Respiratory First Step Pre-Clean.doc

Hello Johnny,

Here is the electronic copy per our conversation.

*Gloria A. Kelley*

Gloria A. Kelley, CRMST

Chief, SPD Intern

G.V. (Sonny) Montgomery VA Medical Center

1500 East Woodrow Wilson Drive

Jackson, MS 39216-5199

Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440

Fax: (601) 368-4171

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**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Friday, January 22, 2010 1:18 PM  
**To:** Herbert, Billie S (VHAJAC)  
**Cc:** Lewis, Beverly R. (VHAJAC)  
**Subject:** Product Evaluation GU First Step Pre-Clean  
**Attachments:** Product Evaluation GU First Step Pre-Clean.doc

Hello Billie,

Here is the electronic version of the product evaluation form per our conversation.

Thank you,

*Gloria A. Kelley*

Gloria A. Kelley, CRMST

Chief, SPD Intern

G.V. (Sonny) Montgomery VA Medical Center

1500 East Woodrow Wilson Drive

Jackson, MS 39216-5199

Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440

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**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Friday, January 22, 2010 1:30 PM  
**To:** Barnes, Lagrace  
**Cc:** Lyons, Larry J. (VHAJAC)  
**Subject:** Product Evaluation OR Enzymatic Spray  
**Attachments:** Product Evaluation OR Enzymatic Spray.doc

Hello Lagrace,

Here is the electronic version of the product evaluation form that was provided.

Thank you,

*Gloria A. Kelley*

Gloria A. Kelley, CRMST

Chief, SPD Intern

G.V. (Sonny) Montgomery VA Medical Center

1500 East Woodrow Wilson Drive

Jackson, MS 39216-5199

Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440

Fax: (601) 368-4171

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**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Thursday, March 04, 2010 9:15 AM  
**To:** Acosta, Carla L. (VHAJAC)  
**Subject:** RE: VHA Directive/Handbook 7176

Carla,

The training will take place at the SPD in Little Rock however, I don't know when. I have no idea where you'll be sitting as there really isn't any unoccupied spaces in SPD. Congratulations on your marriage and have a fabulous time on your honeymoon.

---

**From:** Acosta, Carla L. (VHAJAC)  
**Sent:** Thursday, March 04, 2010 8:51 AM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Cc:** Acosta, Carla L. (VHAJAC)  
**Subject:** RE: VHA Directive/Handbook 7176

Gloria,

Thanks a lot for all the information. Do you know when or where the training is for Little Rock? I was told that they don't have anywhere for me to sit yet in SPD so..... I guess it's a waiting game right now. I'll be on my honeymoon from March 15-19. I don't know where I will be located after that.

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Thursday, March 04, 2010 8:35 AM  
**To:** Acosta, Carla L. (VHAJAC)  
**Subject:** RE: VHA Directive/Handbook 7176

Good Morning Carla,

There is Level I training which will be required for you to take and serves as preparation for your Level II certification exam. The entire Level I course is on LMS under SPD and consists of 10 modules with an end of module test in which a score of 80% or better is required before continuing on to the next module. There is a hardcopy of Level I which I will get for you to use.

I look forward to working with you in the future.

Gloria

---

**From:** Acosta, Carla L. (VHAJAC)  
**Sent:** Monday, March 01, 2010 7:06 AM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Cc:** Acosta, Carla L. (VHAJAC)  
**Subject:** RE: VHA Directive/Handbook 7176

Thanks. I found out that it will be a while before I make it down there. They have to get coverage for my desk and I have to attend a training in Little Rock.

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**From:** Scott-Williams, Susan

**Sent:** Wednesday, March 10, 2010 1:13 PM

**To:** Bruce, Lisa B. (VHAJAC); Kelley, Gloria A. (VHAJAC); White-Taylor, Dorothy M. (VHAJAC); Simon, Joan A. (VHAJAC)

**Subject:** FW: Request for Information - RME Technologies

Dear Lisa and all

The following is a list of specific items they are looking for: I know that Gloria shared with me the SPD dashboard QI indicator which is fabulous and could be an example of Quality Control measures.

- **SOP Standardization/Digitalization for RME**
- **Development of Quality Control Measures**
- **RME/SPD Staffing and Resource Capacity Models**
- **RME/SPD Layout Redesign to reduce human errors**
- **Computer Monitored Process Control**
- **Programs to Improve Compliance**
- **Process Modeling and Simulation**
- **RFID-enabled endoscope (or RME) management systems**

This is the response from Little Rock

**FROM CENTRAL ARKANSAS VETERANS HEALTHCARE SYSTEM, LITTLE ROCK,  
ARKANSAS (598)**

Please provide descriptions of initiatives or technologies being developed within your VISN to improve the system and processes of reprocessing RME in any of the following areas:

1. **SOP Standardization/Digitalization of RME:** SOPs and Manuals are stored on the CAVHS RME Sharepoint. OneSource website is used to ensure the most recent manufacturer's guidelines are being followed. CAVHS uses combination of CensiTrac, MS Access and AEMS/MERS to track RME inventory database in SPD.
2. **Development of Quality Control Measures:** Reprocessing Committee conducts weekly rounds and utilizes a Tracer Tool and monitor that is housed on the Sharepoint. Results are shared monthly at the SPD Management Board meeting. The tool also tracks followup of opportunities discovered during rounds.
3. **RME/SPD Layout Redesign to reduce human errors:** Steris equipment was relocated to SPD from the OR. Redesign/re-locate NLR Dental SPD to larger area.
4. **Computer Monitored Process Control:** CensiTrac, MS Access and AEMS/MERS will be utilized to track RME and RME Machines inventory. MS Access was used to create a Flash Sterilization Database to track flash sterilization and patient cases affected by flash. MS Access program being created to track RME, Reprocessing machines, and SOPs governing each. MS Excel spreadsheets used to track and publish certification of technicians.

5. Programs to improve compliance: The SPD Management Board (SPDMB) has the authority and accountability for ensuring reprocessing and other SPD functions occurs to exact standards as described in the VHA directive 2009-031 and 2009-004. Members of the board include Chief of Staff, Associate Medical Center Director, SPD Chief (or equivalent reprocessing Supervisor); Quality Management Chief; Infection Control Nurse Manager; Patient Safety Manager Supervisor; Safety Officer, Chief Logistics, and a representative of Bio-Medical Engineering. This board reports to the Joint Leadership Council. Reprocessing rounds and reporting results via the RME Tracer tool have helped with improved compliance. A RCA aggregate on decreasing incidents of flash sterilization resulted in the development of a Code Flash process to expedite urgent reprocessing needs. Engineering and Industrial Hygiene conduct periodic Air Quality/Exchange Tests and report and publish results quarterly.

---

**From:** Jones, Mary (V16)  
**Sent:** Wednesday, March 03, 2010 2:54 PM  
**To:** VISN 16 ACTION ITEM MAIL  
**Cc:** Scott-Williams, Susan  
**Subject:** FW: Request for Information - RME Technologies

**Action Item**

**Action Item Due Date:** COB March 09, 2010

**Discussion:** The attached is a request for information pertaining to initiatives or technologies being developed within your VISNs to improve the system and processes of reprocessing reusable medical equipment (RME) in specific areas.

**Requested Action:** Review the attached document for specifics regarding types of initiatives or technologies.

**Response Instruction:** Submit your response electronically via Outlook to Susie Scott-Williams with a Copy to the VISN [16.Action@va.gov](mailto:16.Action@va.gov).

**Questions:** If you have questions, contact Susie Scott-Williams at 601-206-6990.

**Attachments:** 1

---

**From:** Levesque, Odette  
**Sent:** Wednesday, March 03, 2010 8:32 AM  
**To:** VHA VISN Directors  
**Cc:** VHA VISN Chief Medical Officers; All VISN QMO; VHA VISN Admin Reps; VHA VISN Assistant Chief Medical Officer; Friel, Megan; Jesse, Robert, MD, PhD; Moore, Kimberly, VHACIN  
**Subject:** Request for Information - RME Technologies

The attached is a request for information pertaining to initiatives or technologies being developed within your VISNs to improve the system and processes of reprocessing reusable medical equipment (RME) in specific areas.

**ACTION:** Refer to the memorandum for specific actions

**DUE DATE:** COB, Thursday, March 11, 2010

**RESPOND TO:** Kimberly Moore via Outlook

**REFER QUESTIONS TO:** Kimberly Moore via Outlook or at (513) 266-8782

*Odette Levesque RN, FACHE*

W- 202-461-7046 (new #)

Fax - 202-273-6593

BB - 202-299-4512

<http://srd.vssc.med.va.gov>.

**... "every system is perfectly designed to get the results that it gets" ... Paul Batalden**

## Kelley, Gloria A. (VHAJAC)

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Thursday, March 11, 2010 11:50 AM  
**To:** Simon, Joan A. (VHAJAC); Bruce, Lisa B. (VHAJAC)  
**Cc:** Kelley, Gloria A. (VHAJAC)  
**Subject:** RE: Request for Information - RME Technologies  
**Attachments:** image001.png

Hello Everyone,

This is all I could come up with in such short notice. I

- SOP Standardization/Digitalization for RME
  - SOPs are in the process of being placed on the facility sharedrive. One Source is an avenue currently being explored for its' benefit of electronically housing manufacturer guidelines and providing timely updates or changes as they occur via update ALERTS.
  - RME inventory is being maintained and tracked via GIP, Censitrac, Microsoft Excel
- Development of Quality Control Measures

A Dashboard was developed to track Organizational dimensions of performance measures and is used to provide for a systematic coordinated and continuous approach to improving performance by focusing on the processes and mechanisms that address these values. These are as follows:

#### Training – An

1. 100% Level 1 Certification
2. Provide minimum of 12 In-service education sessions per year.
3. Continuing education, Level II Certification
4. Maximization of resources via cross-functional utilization of personnel.

#### Service/Satisfaction

5. Develop open lines of communication and dialog with customers.
6. Establish quality levels for the products and services provided.
7. Timely delivery and adequate availability of goods.
8. Ensure all aspects of SPD are continuously evaluated for improvement opportunities.
9. Staff Courtesy

#### Employee of Choice

10. Employee Empowerment
11. Opportunities for increased responsibility
12. Advancement
13. Recognition Awards
14. Performance Cash Awards

#### Quality Control Indicators

15. Reusable Medical Equipment (RME) Process Controls and Indicators
16. Sterilization Measures
17. Sterilization Records, printouts
18. Biological, Chemical, and Mechanical Indicators
19. Environmental Controls
20. OR Reports, Case Cart Audits
21. Outdates, Early Release of non-biological implants

## 22. Customer Surveys

- RME/SPD Layout Redesign to reduce human errors
  - SWOT Analysis is currently underway to determine the feasibility in relocating SPD to another location within the hospital or to leave it in its present location and expand outward.
- Computer Monitored Process Control
  - Censitrac, MS Excel, and GIP are currently being utilized in the tracking of RME assets.
  - **\*\*\* (A MUST HAVE)** Censitrac has a great new ScopeTrac program which will provide:
    - Identify all scopes by manufacturer, model, serial number, unique device ID,
    - Establish reprocessing procedures for each scope, that are easily accessible to staff
    - Track the current location within the facility, age and maintenance history of each endoscope
    - Provide easy access to manufacturer's cleaning instructions
    - You'll be able to provide detailed reprocessing instructions for the technicians
    - See your complete scope inventory at a glance
    - Record history of uses
    - Have accountability of technicians performing the reprocessing, and much more.
    - Step-by-step instructions for reprocessing the scopes displayed on-line
    - Manufacturer's instructional material presented to the technician as they process a scope
    - Electronic recording of technician processing the scope and leak test results
    - Electronic records of disinfecting/sterilizing
    - Traceability to each case a scope is used on
    - Comprehensive scope inventory, locations and history
    - Visibility of scopes due for reprocessing
    - Tracking scope maintenance activity
  - An automated training Matrix is currently under development using MS Excel
- Programs to Improve Compliance
  - Quarterly rounds are being conducted by the (Acting) Chief, SPD, Infection Control, QM, and Patient Safety. Executive rounds are being conducted by the Chief of Staff, Chief QM, and (Acting)Chief, SPD. Rounds are also being made by the QM specialist liaison to SPD as well. These rounds serves as an invaluable means of directly observing personnel throughout the facility who have reprocessing capabilities and ensuring that staff are following manufacture's guidelines to exacting standards. It also presents an opportunity to identify possible deficiencies and take the necessary corrective action in order to improve processes and/or correct performance.

*Gloria A. Kelley*

Gloria A. Kelley, CRMST

Chief, SPD Intern

G.V. (Sonny) Montgomery VA Medical Center

1500 East Woodrow Wilson Drive

Jackson, MS 39216-5199

Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440

Fax: (601) 368-4171

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**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Monday, March 29, 2010 8:50 AM  
**To:** Simon, Joan A. (VHAJAC)  
**Subject:** FW: STERRAD Sterilization Log.xls  
**Attachments:** STEAM Sterilization Log.xls; EtO Sterilization Log.xls; Case Cart Audit Jan 2010.xls; STERRAD Sterilization Log.xls

FYI

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Thursday, March 25, 2010 9:30 AM  
**To:** Johnson, Catherine (VHAJAC)  
**Subject:** STERRAD Sterilization Log.xls

Hello Cat,

Per our previous conversation.

Have a great day!

*Gloria A. Kelley*

Gloria A. Kelley, CRMST  
Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
Fax: (601) 368-4171

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**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Wednesday, April 14, 2010 8:12 AM  
**To:** Simon, Joan A. (VHAJAC)  
**Cc:** White-Taylor, Dorothy M. (VHAJAC); Bruce, Lisa B. (VHAJAC)  
**Subject:** FW: Training Matrix (Autosaved) (version 1).xls  
**Attachments:** Training Matrix (Autosaved) (version 1).xls

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Wednesday, April 14, 2010 8:10 AM  
**To:** Simon, Joan A. (VHAJAC)  
**Cc:** Kelley, Gloria A. (VHAJAC)  
**Subject:** Training Matrix (Autosaved) (version 1).xls

Good Morning Joan,

Here is the Training Matrix for the areas reprocessing RME at the facility. This management tool is still in the developmental stage.

*Gloria A. Kelley*

Gloria A. Kelley, CRMST

Chief, SPD Intern

G.V. (Sonny) Montgomery VA Medical Center

1500 East Woodrow Wilson Drive

Jackson, MS 39216-5100

Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440

Fax: (601) 368-4171

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**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Tuesday, April 27, 2010 1:44 PM  
**To:** Acosta, Carla L. (VHAJAC)  
**Subject:** RE: SPD Trainings

Hello Carla,

The Level I material, SPD videos, 7176, and the hands on training that you're getting is all that you need. You will succeed, you already have! (SMILE). Sorry in the delay in responding however, I've begun my OR rotation and it has literally commanded all of my time and curiosity, it is fantastic. Continue to hang in there and devour as much information as possible to bring back to Jackson. Have a great day!

Gloria

---

**From:** Acosta, Carla L. (VHAJAC)  
**Sent:** Monday, April 26, 2010 1:00 PM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Cc:** Acosta, Carla L. (VHAJAC)  
**Subject:** SPD Trainings

Gloria,

Do you have any information, besides the level 1 training, that I can study for the level 2 training?

Thanks,

*Carla L. Acosta* AAS, BSHM  
Assistant Chief, SPD  
Patient Care Services  
G.V. "Sonny" Montgomery VAMC  
1500 E Woodrow Wilson Ave  
Jackson, MS 39216

**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Monday, June 07, 2010 1:05 PM  
**To:** Johnson, Catherine (VHAJAC)  
**Cc:** Simon, Joan A. (VHAJAC); Acosta, Carla L. (VHAJAC)  
**Subject:** FW: STERRAD Sterilization Log.xls  
**Attachments:** STEAM Sterilization Log.xls; EtO Sterilization Log.xls; Case Cart Audit Jan 2010.xls; STERRAD Sterilization Log.xls

Hello Carla,

Inadvertently left you off this correspondence, sorry!

*Gloria A. Kelley*

Gloria A. Kelley, CRMST  
Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
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---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Monday, June 07, 2010 1:01 PM  
**To:** Johnson, Catherine (VHAJAC)  
**Cc:** Simon, Joan A. (VHAJAC); Kelley, Gloria A. (VHAJAC)  
**Subject:** STERRAD Sterilization Log.xls

Catherine,

Per our previous conversation.

*Gloria A. Kelley*

Gloria A. Kelley, CRMST  
Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
Fax: (601) 368-4171

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**Kelley, Gloria A. (VHAJAC)**

---

**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Wednesday, July 07, 2010 3:41 PM  
**To:** Simon, Joan A. (VHAJAC)  
**Cc:** Acosta, Carla L. (VHAJAC)  
**Subject:** Site Review Guide Final may 09 (3).xls  
**Attachments:** Site Review Guide Final may 09 (3).xls

FYI

*Gloria A. Kelley*

Gloria A. Kelley, CRMST  
Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
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**Kelley, Gloria A. (VHAJAC)**

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**From:** Windham, Melinda (V16)  
**Sent:** Monday, October 18, 2010 8:31 AM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Subject:** Contracting Training

**Importance:** High

Gloria,

Please make plans to return to the VAMC Monday if you haven't already. I'm sure VISN management is not going to agree for you to continue your training over here after I leave, and I don't want there to be any issues.

The P&C staff has expressed their appreciation for your assistance and second set of eyes on their documents, as well. I wish you continued success and have absolutely no doubt you have a promising and bright future ahead of you. You have truly been an inspiration to me, and I appreciate your support.

Many blessings to you and your family.

Melinda Windham  
Chief of Purchasing & Contracting  
715 S. Pear Orchard Road  
Plaza I Building, 4th Floor  
Ridgeland, MS 39157  
Phone: 601-206-6952

## **Kelley, Gloria A. (VHAJAC)**

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**From:** Windham, Melinda (V16)  
**Sent:** Thursday, October 21, 2010 3:56 PM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Subject:** FW: URGENT RESPONSE REQUESTED

Any thoughts?

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**From:** Simon, Joan A. (VHAJAC)  
**Sent:** Thursday, October 21, 2010 3:23 PM  
**To:** Windham, Melinda (V16)  
**Subject:** RE: URGENT RESPONSE REQUESTED

Dr. Taylor is out this week but will return next week. Can she complete her training with someone else at your facility. It is my understanding if she should go to another facility Jackson will have to pay her per diem and her travel.

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**From:** Windham, Melinda (V16)  
**Sent:** Thursday, October 21, 2010 3:18 PM  
**To:** Simon, Joan A. (VHAJAC)  
**Subject:** RE: URGENT RESPONSE REQUESTED

So you don't want me to clear some time in November or December with another station for her to complete her contracting training? Next week will be too soon for approval, but maybe November and December.

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**From:** Simon, Joan A. (VHAJAC)  
**Sent:** Thursday, October 21, 2010 3:15 PM  
**To:** Windham, Melinda (V16)  
**Cc:** Simon, Joan A. (VHAJAC); Acosta, Carla L. (VHAJAC); Fredericks, Grayland G. (VHAJAC)  
**Subject:** RE: URGENT RESPONSE REQUESTED

Melinda,

She can return to the VAMC on Monday. I will set up for her to go to AM&M to rotate with Grayland Fredericks and George Jeffcoat until her scheduled CON training November 8 – 19, 2010.

Thanks.

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**From:** Windham, Melinda (V16)  
**Sent:** Thursday, October 21, 2010 2:59 PM  
**To:** Simon, Joan A. (VHAJAC)  
**Subject:** URGENT RESPONSE REQUESTED  
**Importance:** High

Joan,

I can't recall if I told you or not, but this is my last week with the VA. I advised Gloria to return back to the VAMC on Monday which means she will not have completed all the contracting training indicated in her training syllabus, so I would like to know if it's okay with you if I ask another Chief of P&C if she can visit their facility to complete her training requirements. I'm considering either New Orleans, Shreveport, Biloxi, or Alexandria. I have heard Gloria say VACO or whomever is sponsoring the intern program is very supportive of the interns' training needs and will provide funding. Please let me know if this is okay before I contact another office.

Melinda Windham  
Chief of Purchasing & Contracting  
715 S. Pear Orchard Road  
Plaza I Building, 4th Floor  
Ridgeland, MS 39157  
Phone: 601-206-6952

**Kelley, Gloria A. (VHAJAC)**

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**From:** White-Taylor, Dorothy M. (VHAJAC)  
**Sent:** Monday, January 31, 2011 6:49 PM  
**To:** VHAJAC RME (Reusable MED Equipment)  
**Cc:** White-Taylor, Dorothy M. (VHAJAC)  
**Subject:** FW: Cleaning Equipment

**Importance:** High

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**From:** White-Taylor, Dorothy M. (VHAJAC)  
**Sent:** Monday, January 31, 2011 6:48 PM  
**To:** VHAJAC Nurse Exec; VHAJAC Head Nurses (NS); VHAJAC NUR COORDINATORS  
**Cc:** White-Taylor, Dorothy M. (VHAJAC)  
**Subject:** Cleaning Equipment  
**Importance:** High

**Reminder**

Staff are to be specific as to the time frames high level disinfectants and cleaning solutions are to be in contact with the equipment to disinfect and/or clean equipment.

One of the surveyors asked a staff member how long did they leave a solution on the equipment and the staff member replied – “Oh, we just spray it on there and wipe it off.” The cleaning solution bottle said “1 minute”. This was not the right answer.

So..., please remind your staff (and yourself) to either know the answer or at least read the can before spraying.

D

## Kelley, Gloria A. (VHAJAC)

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**From:** Kelley, Gloria A. (VHAJAC)  
**Sent:** Friday, February 18, 2011 2:12 PM  
**To:** Simon, Joan A. (VHAJAC)  
**Cc:** Kelley, Gloria A. (VHAJAC)  
**Subject:** RE: SPD CHIEF INTERN

Hello Joan,

The training information about me had been provided to Mr. Bowling in Biloxi, MS was inaccurate. I don't understand why my training accomplishments had been under represented in the email dated January, 25, 2011, however, I would greatly appreciate it in the future when training information about me is disseminated to others, that it comes from a source knowledgeable of my training requirements and accomplishments.

As it was discussed and recommended by an Office of Medical Inspection (OMI) inspector, during an October 2009 Investigation here at the Jackson VA Medical Facility, it is imperative for me to train with an experienced SPD Chief. This is the reason and purpose for me having to go to another facility to train. So, with the exception of the items that I've highlighted in yellow below as not yet accomplished, added to this list is the training with an experienced SPD Chief.

I am looking forward to attending the training at the Biloxi VA facility with the SPD Chief and staff members. Additionally, I would like to thank you for forwarding me this email to bring me up to date and into the loop on what has been happening behind the scenes with my training.

### CORRECTED VERSION

Just a few Training Specifics & Activities that will occur: (Has 1-2 or 1-3 been accomplished?)

1. Complete Level One SPD Training COMPLETED
2. Attend SPD Level II Training COMPLETED
3. Obtain SPD Certification (CRMST) – *has this been achieved?* COMPLETED
4. Participate in on-the-job training, including extensive rotations in the following areas within SPD: decontamination, preparation, and sterilization.-COMPLETED
5. Develop infection control skills-COMPLETED
6. Develop staff education skills-COMPLETED
7. Rotate through each of the services that SPD has significant interaction with, including the operating room COMPLETED, Nursing Service, Engineering Service (e.g., Bio-Med), Infection Control, and \*Inventory Management COMPLETED.
  - o \*Having Inventory Management knowledge is essential in successfully procuring reprocessing equipment such as sterilizers, leak testers, etc. -COMPLETED
8. Attend facility level committee meetings, including:
  - o Commodity Standards Committee COMPLETED
  - o Infection Control Committee COMPLETED
  - o Critical care Committee
  - o Capital Asset Management Committee- COMPLETED TRAINING ONLY
  - o Surgical Invasive Committee
  - o RME Management Committee COMPLETED

Thank you,

*Gloria A. Kelley*  
Gloria A. Kelley, CRMST, CRCST

Chief, SPD Intern  
G.V. (Sonny) Montgomery VA Medical Center  
1500 East Woodrow Wilson Drive  
Jackson, MS 39216-5199  
Phone#: (601) 362-4471 Ext. 3010 / Pager# 1440  
Fax: (601) 368-4171

IMPORTANT NOTICE: This communication, including any attachments, contains information that may be confidential. It is intended solely for the individual or entity to whom it is addressed. If you are not the intended recipient, please notify me at [gloria.kelley@va.gov](mailto:gloria.kelley@va.gov) and delete this message. You are hereby notified that any disclosure, copying, or distribution of this message is strictly prohibited. Nothing in this e-mail, including any attachment, is intended to be a legally binding signature.

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**From:** Simon, Joan A. (VHAJAC)  
**Sent:** Friday, February 18, 2011 12:11 PM  
**To:** Kelley, Gloria A. (VHAJAC)  
**Subject:** FW: SPD CHIEF INTERN

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**From:** Acosta, Carla L. (VHAJAC)  
**Sent:** Wednesday, January 26, 2011 10:11 AM  
**To:** Bowling, John H.; Knause, Joseph C.  
**Cc:** White-Taylor, Dorothy M. (VHAJAC); Simon, Joan A. (VHAJAC); Acosta, Carla L. (VHAJAC)  
**Subject:** RE: SPD CHIEF INTERN

Ms. Kelley has completed Information Security and Privacy Awareness and the items annotated below.

Thanks,  
Carla

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**From:** Bowling, John H.  
**Sent:** Tuesday, January 25, 2011 10:58 AM  
**To:** Acosta, Carla L. (VHAJAC); Knause, Joseph C.  
**Cc:** White-Taylor, Dorothy M. (VHAJAC); Simon, Joan A. (VHAJAC)  
**Subject:** RE: SPD CHIEF INTERN

Approval has been granted for receiving your SPD Chief (Intern) for training in March and our facility is looking forward to sharing process. Please validate that all of her mandatory training has or will be completed and current so that she can have computer access here in Biloxi. Such as Information Security, VA Privacy Awareness Training, Cyber Security Awareness, etc. Joe Knause is our Assistant Chief of SPD and he will also be able to provide her with great information.

Just a few Training Specifics & Activities that will occur: (Has 1-2 or 1-3 been accomplished?)

9. Complete Level One SPD Training COMPLETED
10. Attend SPD Level II Training COMPLETED
11. Obtain SPD Certification (CRMST) – *has this been achieved?* COMPLETED
12. Participate in on-the-job training, including extensive rotations in the following areas within SPD:  
decontamination, preparation, and sterilization.
13. Develop infection control skills

14. Develop staff education skills
15. Rotate through each of the services that SPD has significant interaction with, including the operating room COMPLETED, Nursing Service, Engineering Service (e.g., Bio-Med), Infection Control, and \*Inventory Management COMPLETED.
  - o \*Having Inventory Management knowledge is essential in successfully procuring reprocessing equipment such as sterilizers, leak testers, etc.
16. Attend facility level committee meetings, including:
  - o Commodity Standards Committee COMPLETED
  - o Infection Control Committee COMPLETED
  - o Critical care Committee
  - o Capital Asset Management Committee
  - o Surgical Invasive Committee
  - o RME Management Committee COMPLETED

John H. Bowling, RN  
Chief, SPD  
VA Gulf Coast Health Care System  
400 Veterans Ave.  
Biloxi, MS 39531  
228-523-4939 tel  
228-208-0077 pager

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**From:** Acosta, Carla L. (VHAJAC)  
**Sent:** Monday, January 03, 2011 3:06 PM  
**To:** Bowling, John H.  
**Cc:** White-Taylor, Dorothy M. (VHAJAC); Simon, Joan A. (VHAJAC); Acosta, Carla L. (VHAJAC)  
**Subject:** SPD CHIEF INTERN

John,

Just checking in on the possible rotation for our intern to visit/train in Biloxi. We are looking at her being down there for about a month somewhere around March. Please let me know when this is approved on your end so we can start the paperwork on this end.

Thanks,  
Carla Acosta  
Asst. Chief, SPD

June 26, 2009

**IMPROVING SAFETY IN THE USE OF REUSABLE MEDICAL EQUIPMENT  
THROUGH STANDARDIZATION OF ORGANIZATIONAL STRUCTURE AND  
REPROCESSING REQUIREMENTS**

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive provides specific requirements for the organizational structure charged with oversight responsibilities for reprocessing specified reusable medical equipment (RME) at the Veterans Integrated Service Network (VISN) and Facility levels, and includes specific guidance for standardization of equipment types and for ensuring that reprocessing requirements are met. This Directive applies to RME, which requires High Level Disinfection or Sterilization in order to be reused on another patient. *NOTE: This Directive augments previous Department of Veterans Affairs (VA) Central Office policies issued to assure quality in the setup, use and reprocessing of reusable medical equipment.*

**2. BACKGROUND:** The safe use of RME depends on good manufacturing practices, including the uniform implementation of current manufacturers' instructions for cleaning and disinfection and sterilization (reprocessing).

b. Endoscopic procedures are inherently safe with infection rates in the range of 1 in 1.8 million procedures; virtually every case of pathogen transmission related to an endoscopic procedure has ultimately been attributed to failure to follow established reprocessing guidelines or to the use of defective equipment. Proper reprocessing of RME is a key component to ensuring patient and staff safety, and therefore must be performed to exacting standards.

c. Consistency and high reliability in the reprocessing of RME across unit, facility, VISN, and national levels requires a uniform chain of command and accountability over all such processes.

**3. POLICY:** It is VHA policy that each VHA facility must have a systematic standardization and oversight plan for reprocessing RME according to current manufacturers' instructions and systematically retire and replace older equipment in place, and that each VISN must have a Supply, Processing, and Distribution (SPD) Management Board established and functioning no later than September 1, 2009.

**4. ACTION**

a. **Chief, Patient Care Services (11).** The Chief, Patient Care Services (11), is responsible for:

(1) Continued development and oversight of national policy pertaining to the standardization and reprocessing of RME.

**THIS VHA DIRECTIVE EXPIRES FEBRUARY 28, 2014**

**VHA DIRECTIVE 2009-031**

**June 26, 2009**

(2) Development, in collaboration with the Office of Quality and Safety, national Quality Management, metrics to ensure expected actions and outcomes are met.

b. **Office of the Deputy Under Secretary for Health for Operations and Management.** Office of the Deputy Under Secretary for Health for Operations and Management, in cooperation with Chief Consultant Medical Surgical Service, is responsible for ensuring this policy is effectively deployed and implemented by the VISNs and facilities.

c. **VISN Director.** Each VISN Director is responsible for:

(1) Appointing a VISN SPD Management Board, no later than September 1, 2009, charged with the oversight of SPD at the VISN level to specifically include all reprocessing of RME occurring within the VISN.

(a) Members of the VISN SPD Management Board must have specialized knowledge of the reprocessing of RME.

(b) Board membership must include, at a minimum, an:

1. Nurse Executive,
2. Associate Director,
3. Safety Officer,
4. Chief Medical Officer or Quality Management Officer,
5. Practitioner of Infection Control,
6. Chief of Staff, and
7. Chief, SPD.

(c) The SPD Management Board has the authority and accountability for ensuring reprocessing (and other SPD functions) occurs to exacting standards, i.e., current manufacturer's instructions, across the VISN facilities as described in this Directive and in VHA Directive 2009-004, dated February 9, 2009, "Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities."

(2) Ensuring that facility Directors comply with the actions contained within this Directive and they are actively engaged with the oversight of all RME reprocessing.

(3) Verifying that Infection Control, Training, and Quality Management programs at each facility within the VISN are in place

d. **Facility Director.** The Facility Director is responsible for:

(1) Ensuring the Chief of SPD (or equivalent, e.g., a Director of Sterile Processing), is delegated responsibility for reprocessing of RME wherever reprocessing occurs throughout the facility and affiliated sites (e.g., Community-based Outpatient Clinics).

(2) Standardization of RME is effected in order to facilitate consistency and efficiency in setup, use, and reprocessing, whether through facility-owned equipment or through a leasing agreement. *NOTE: Exceptions must have the written concurrence of the Chief Consultant, Medical Surgical Services (111).*

(3) Equipment is replaced uniformly throughout the facility, when needed. This is a key component to the standardization process.

(4) Ensuring there is a plan in place, no later than September 1, 2009, to systematically retire and replace older equipment, as well as that from different manufacturers, in order to maintain uniformity in the equipment used for any given procedure.

(5) Initial and ongoing training programs for the Infection Control Program, Quality Management Program, Competency Management Program, Equipment Maintenance Program, and Repair for Medical Equipment Program are in place. *NOTE: These need to be considered as integral components to any purchase or lease arrangements.*

(a) These training programs must include the initial implementation of standard operating procedures (SOP) governing the setup, use, reprocessing, a method for periodic review (at a minimum annually), and a plan for implementing any changes to a given SOP.

(b) Independent repair maintenance contracts or in-house service agreements need to be executed in order to ensure adherence with current manufacturers' maintenance and repair guidelines.

(6) Processes for determining which equipment is to be utilized involve all the stakeholders and include the needs and training of the operator, infection control, logistics, SPD, and Biomedical Engineering.

(7) SPD has input into any:

(a) Decisions that impact or require SPD-related functions or support, specifically including the purchase and lease of any medical equipment requiring reprocessing or consumable supplies.

(b) Facility construction projects where medical equipment is used or reprocessed, or where supplies are to be stored.

(8) The following is verified:

(a) All requirements for training and documentation of competencies are in place,

**VHA DIRECTIVE 2009-031**

**June 26, 2009**

(b) SOPs are available and are being followed, and

(c) Quality systems are in place, being appropriately reported, and when necessary, corrective action(s) is taken.

(9) There is, for all quality control programs, documentation of testing procedure(s), (including locations, the serial number or unique identifier for scopes, solution lot numbers, identification of automated washer or disinfectors, etc.), the results of the testing, and any actions taken. This information must be maintained and reviewed by the Infection Prevention and Control Committee, or equivalent oversight group, at least on a quarterly basis.

(10) Biomedical Engineering reviews all requests for independent repair maintenance contracts or in-house service agreements.

e. **Nurse Executive.** The Nurse Executive is responsible for the day-to-day supervision of local SPD operations and ensures the Chief of SPD, or equivalent, implements all provisions of subparagraph 4f.

f. **Chief of SPD.** The Chief of SPD, or equivalent, is responsible for ensuring:

(1) The facility's reprocessing of all RME is performed with high reliability according to current manufacturers' instruction wherever these processes are performed and regardless of who is performing them.

(2) Any and all individuals charged with reprocessing duties are appropriately trained and competent in performing the assigned tasks, and when SOPs are changed all designated staff are retrained and competency is again established. Personnel reprocessing RME must be continually evaluated to ensure that they are demonstrating proficiency in all reprocessing activities and meeting all critical elements in their performance standards relating to RME. Appropriate training must be done whenever new or different equipment is used; new critical elements related to reprocessing must be added to performance standards, as necessary. Temporary personnel must not be permitted to reprocess RME until training has been completed and proficiency has been demonstrated.

(3) Specific processes and procedures are in place for any given RME. This includes, but is not limited to following specific guidance regarding the use and reprocessing of endoscopes:

(a) All clinical and technical personnel involved in endoscope use and reprocessing are to be trained in standard infection control methods, including those to protect both patients and themselves.

(b) SOPs reflecting current manufacturers' instructions must be available in each area where reprocessing occurs for each type of endoscopic equipment used. Personnel assigned to reprocess endoscopes must be trained according to device-specific SOPs in order to ensure proper cleaning and high-level disinfections and sterilization.

(c) All SOPs must be kept up-to-date, and methods in place to sequester outdated versions and to disseminate revised SOPs, as well as to ensure compliance and competence in the execution of any revised procedure.

(d) A method is in place to identify that a given RME has been reprocessed; if not clearly identified as having been done, it must be reprocessed before use. A system or log is in place to record, for each instance of use, the:

1. Serial number, or other unique identifier, of the endoscopic equipment used for each patient procedure.

2. Specific procedure, operator(s), date and time, and patient identifier.

(e) A quality management program must be in place to ensure appropriate and safe reprocessing is being performed. While this is required for all RME, the following examples related to endoscopes are all highly recommended:

1. Testing to ensure bio-burden has been removed after reprocessing endoscopes that have been used for biopsy, (both the biopsy and suction channels).

2. Routine testing of liquid disinfectant and sterilization solutions to ensure minimal effective concentrations of the active ingredients, and that these solutions are discarded at the end of their prescribed reuse life, regardless of effective concentration.

3. Site inspections to ensure personnel are using appropriate protective equipment to protect against exposure to chemicals, blood, or potentially infectious materials.

4. Testing adequacy of ventilation systems in cleaning areas to ensure that vapor concentrations of sterilizing solutions do not exceed allowable standards.

## 5. REFERENCES

a. Guidelines for use of high level disinfectants and sterilants for reprocessing flexible gastrointestinal endoscopes, Society of Gastroenterology Nurses and Associates, Inc. pages 1-24, 2007.

b. Multi-society Guidelines for Reprocessing Flexible Gastrointestinal Endoscopes, Gastrointestinal Endoscopy, Volume 58, No. 1, 2003.

c. VHA Directive 2009-004, Use and Reprocessing of Reusable Medical Equipment (RME) in Veterans Health Administration Facilities, dated February 9, 2009.

*NOTE: Facilities need to be aware that current manufacturer's instructions and guidance needs to be followed.*

**VHA DIRECTIVE 2009-031**

**June 26, 2009**

**6. FOLLOW-UP RESPONSIBILITY:** The Office of Patient Care Services (11) is responsible for the content of this Directive. Questions may be addressed to National Director, Infectious Diseases, through the Office of Medical Surgical Services at (202) 461-7120.

**7. RESCISSIONS:** None. This VHA Directive expires February 28, 2014.

Gerald M. Cross, MD, FAAFP  
Acting Under Secretary for Health

**DISTRIBUTION:** E-mailed to the VHA Publications Distribution List 6/26/2009

February 9, 2009

**USE AND REPROCESSING OF REUSABLE MEDICAL EQUIPMENT (RME) IN  
VETERANS HEALTH ADMINISTRATION FACILITIES**

**1. PURPOSE:** This Veterans Health Administration (VHA) Directive provides procedures for the design and implementation of a systematic approach for the set up, proper use, reprocessing, and maintenance of all reusable medical equipment (RME) used in VHA facilities.

**2. BACKGROUND**

a. The safe performance of procedures involving RME requires a systematic process including, but not limited to: initial training of personnel, proper setup, use, and reprocessing for each occurrence; an annual validation of the competency of the staff involved; and quality oversight. The details for each of these steps can effectively be documented in a locally-established standard operating procedure (SOP).

b. Multiple professional disciplines and many different types of RME used across a spectrum of clinical services are involved. For this reason, clear lines of responsibility and accountability must be established to ensure proper outcomes of the identified procedures, SOPs, competency requirements, quality monitoring processes, and clear identification of oversight and accountability for every step and handoff in the process.

c. **Definitions**

(1) **Reusable Medical Equipment (RME).** RME is any medical equipment designed by the manufacturer to be reused for multiple patients. All RME must be accompanied by reprocessing instructions provided by the manufacturer.

(2) **Standard Operating Procedure (SOP).** An SOP is a document detailing all steps and activities of a process or procedure that is dated and signed by an approving official.

(3) **Reprocessing.** Reprocessing is the cleaning, disinfection, sterilization, and preparation of equipment to full readiness for its subsequent use. This can occur in part or in whole, either inside or outside of Supply, Processing, and Distribution (SPD).

(4) **Set-up.** Set-up is the process of assembling the RME in preparation for a procedure in accordance with manufacturer's instructions.

(5) **Competency.** Competency is the assurance that an individual has received the appropriate training and has demonstrated an achieved skill level required to independently and appropriately perform an assigned task or responsibility.

(6) **Quality Assurance.** Quality assurance is the process for continuously monitoring the processes and outcomes of a pre-determined procedure to ensure safe patient care.

**THIS VHA DIRECTIVE EXPIRES FEBRUARY 28, 2014.**

**VHA DIRECTIVE 2009-004**

**February 9, 2009**

(7) **Maintenance.** Maintenance includes the actions taken, in accordance with manufacturer's instructions, to preserve the optimal and safe usefulness of medical equipment and its associated accessories.

**3. POLICY:** It is VHA policy that systematic and local standard processes are developed in compliance with manufacturer's instruction, infection prevention and control principles, and effectively communicated and deployed to staff wherever procedures using RME are performed.

**4. ACTION**

a. **Infectious Diseases Program of the Office of Patient Care Services.** The National Director of the Infectious Diseases Program, Office of Patient Care Services, is responsible for:

(1) The development of national policy pertaining to the reprocessing of RME, and

(2) Liaising with the Networks and the Office of the Deputy Under Secretary for Health for Operations and Management.

b. **Network Director.** The Network Director is responsible for:

(1) Establishing a continuing oversight function, coordinated by the Network Chief Medical Officer, using subject matter experts.

(2) Conducting, at least annually, unannounced site audits of each facility in their Network, that must include.

(a) Ensuring that RME systematic processes are fully implemented and executed at all facilities.

(b) Ensuring that appropriate training is provided and completed for all users of RME prior to initial use.

(c) Ensuring competencies are documented and SOPs exist for each RME and are current and correct based upon manufacturer's written instructions.

(d) Ensuring identification of accountability, responsibility and documented performance at each step in the process.

(e) Ensuring a quality assurance process is established.

(f) Ensuring assigned staff are collecting data, conducting an analyses, and taking required actions to ensure safe and effective use of RME.

(3) Ensuring that local standards and systematic RME processes are established and documented in a SOP within any medical facilities under the purview of VHA that perform procedures utilizing RME.

c. **Facility Director.** The Facility Director is responsible for ensuring:

(1) All personnel that are in any way involved in the use and reprocessing of RME have documented training on the setup, use, reprocessing, and maintenance of the specific equipment leading to initial competency and validation of that competency on an annual basis.

(a) The duties and expected outcomes must be clearly evident in the staff's position description and functional statements and must be identified as a critical element in their annual performance standards.

(b) The language and process for validation is a collaborative effort with the standards being established by the highest level of authority within the medical center on each of the following elements: reprocessing, disinfection, sterilization, maintenance and incorporation of manufacturer's instructions.

(2) That device-specific standards and systematic RME processes are established and documented in a SOP that includes at least the following elements:

(a) Defined process and accountability for performing and documenting initial competency for staff, including required training to be accomplished prior to initial use.

(b) Process and accountability for validating continued staff competency at least annually.

(c) Process and accountability for setup of RME equipment based on manufacturer's instructions.

(d) Process and accountability for reprocessing and maintenance of equipment and supplies utilized in RME procedures.

(e) Organizational structure that includes an interdisciplinary approach to monitoring the compliance with the established process(es) and documents outcomes related to the defined process(es).

(f) Interdisciplinary approach requires participation by Chief, SPD; a representative of Quality and Risk Management; a Nursing Service representative; an Infection Control Professional; a Patient Safety manager; and a representative of Bio-Medical Engineering.

(g) Reporting required to the Executive Committee of the Medical Staff, including, but not limited to: validation of initial and on-going competency of staff, results of compliance with established SOPs, results of infection prevention and control monitoring, and risk management related activities.

(3) That device-specific SOPs for set up and reprocessing of RME are posted in any area where these devices are reprocessed.

**VHA DIRECTIVE 2009-004**

**February 9, 2009**

d. **Associate Medical Center Director, Nurse Executive, or Chief of Staff.** The Associate Medical Center Director, Nurse Executive, or Chief of Staff is responsible for execution of the defined process(es), including, but not limited to:

(1) Ensuring that all staff involved in RME processes have clearly defined responsibilities within their position descriptions or functional statements.

(2) Ensuring that all staff involved in RME processes have clearly-defined performance standards that are identified as critical elements in performance appraisals.

(3) Ensuring implementation of a systematic approach to the performance of procedures involving RME throughout the facility and associated sites.

(4) Ensuring collaboration of all organizational structures within the facility to achieve a comprehensive monitoring system that supports safety and quality in the performance of procedures involving RME.

e. **Chief, SPD.** The Chief, SPD, is responsible for:

(1) Technical oversight of all reprocessing of RME and equipment used in reprocessing wherever such reprocessing occurs within the facility, regardless of organizational alignment.

(2) Development, administration, and validation of initial and annual competencies for staff performing reprocessing of RME and for all personnel involved in using the reprocessing equipment.

(3) Ensuring all functions of SPD, regardless of organizational alignment, are functioning effectively; this includes: decontamination, preparation, case cart and distribution, etc.

**5. REFERENCE**

a. Centers for Disease Control and Prevention, Rutala, William A., Weber, David J. and the Healthcare Infection Control Practices Advisory Committee. Guidelines for Disinfection and Sterilization in Healthcare Facilities, 2008.

b. VA Handbook 7176, Supply, Processing, and Distribution (SPD), Operational Requirements.

**6. FOLLOW UP RESPONSIBILITY:** The Office of Patient Care Services (11) is responsible for the contents of this Directive. Questions regarding the administrative components may be referred to the Chief Consultant Medical Surgical Services (111) at (202) 461-7120. Questions related to the technical components of this Directive may be referred to the Infectious Diseases Program Office at (513) 475-6398.

February 9, 2009

7. **REVISIONS:** None. This VHA Directive expires February 28, 2014.

Michael J. Kussman, MD, MS, MACP  
Under Secretary for Health

**DISTRIBUTION:** CO: E-mailed 2/9/2009  
FLD: VISN, MA, DO, OC, OCRO, and 200 – E-mail 2/9/2009

## OCCUPATIONAL SAFETY AND HEALTH (OSH) PROGRAM PROCEDURES

**1. REASON FOR ISSUE.** This revised Veterans Health Administration (VHA) Handbook establishes procedures and standards for the Occupational Safety and Health (OSH) Program. It updates the VHA OSH Program to conform to Department of Veterans Affairs (VA) Directive 7700. The procedures and standards in this Handbook are mandatory.

**2. SUMMARY OF CONTENTS.** This VHA Handbook contains VHA OSH Program procedures for the prevention of injuries and illnesses, including requirements for:

a. Reducing or eliminating work-related injuries and illnesses and for minimizing the severity of those injuries and illnesses that occur.

b. Establishing a VHA Safety and Health Leadership Committee.

c. Establishing training requirements.

d. Record-keeping and reporting.

e. Recognizing outstanding OSH achievements.

**3. RELATED PUBLICATIONS.** VHA Directive 7701.

**4. RESPONSIBLE OFFICE.** The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for the contents of this VHA Handbook. Questions may be addressed Director (10NS) to 202-461-4547.

**5. RESCISSIONS.** VHA Handbook 7701.1, dated March 26, 2003, is rescinded.

**6. RECERTIFICATION.** This VHA Handbook is scheduled for recertification on or before the last working day of August 2015.

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Under Secretary for Health

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## OCCUPATIONAL SAFETY AND HEALTH (OSH) PROGRAM PROCEDURES

### 1. PURPOSE

This Veterans Health Administration (VHA) Handbook establishes procedures and standards for the VHA Occupational Safety and Health (OSH) Program.

### 2. AUTHORITY

The authorities to implement the VHA OSH Program are found in:

- a. Public Law (Pub. L.) 91-596.
- b. Executive Order (E.O.) 12196, OSH Programs for Federal Employees and the Occupational Safety and Health Program.
- c. Title 29, Code of Federal Regulations (CFR), Part 1960, Basic Program Elements for Federal Employee OSH Programs and Related Matters.
- d. Department of Veterans Affairs (VA) Directive 7700.
- e. VHA Directive 7701.

### 3. SCOPE

This VHA Handbook applies to:

- a. All VHA-owned and leased properties and VA entities co-located at VHA facilities.
- b. All VA-compensated and non-compensated employees who work in VHA facilities.
- c. All VHA employees working at non-VHA facilities.

### 4. OBJECTIVES

The objectives of the VHA OSH Program are to:

- a. Provide a safe and healthful work environment for all VHA employees and volunteers.
- b. Ensure compliance with Federal regulations, E.Os., and VA and VHA policies.
- c. Identify a formal process for VHA Offices located within the Veterans Integrated Service Network (VISN), but outside of the authority of the VISN (e.g., Consolidated Mail Outpatient Pharmacies (CMOPs)), and VA Offices and Administrations located in the VISN, that request OSH services and technical support from VHA VISN staff.

- d. Establish VHA national, VISN, and facility-level Safety and Health Leadership Committees.
- e. Ensure that all VHA facilities implement comprehensive OSH programs to reduce or eliminate work-related injuries and illnesses.
- f. Minimize the severity of injuries and illnesses that do occur.
- g. Establish training requirements for the VHA OSH Program.
- h. Establish OSH record-keeping and reporting requirements.
- i. Establish VHA national, VISN, and facility-level OSH Awards Programs to acknowledge outstanding achievements.

## **5. STANDARDS**

Federal regulations and generally accepted industry standards applicable to worker protection define the scope and direction of the VHA OSH Program. These include:

- a. Occupational Safety and Health Administration (OSHA) 29 CFR.
- b. Environmental Protection Agency (EPA) 40 CFR.
- c. Department of Transportation (DOT) 49 CFR.
- d. Nuclear Regulatory Commission (NRC) 10 CFR.
- e. E.Os.
- f. The Joint Commission (TJC) Standards.
- g. National Fire Protection Association (NFPA) Standards.
- h. Applicable state and local standards.
- i. Applicable VA and VHA Directives and Handbooks.

## **6. RESPONSIBILITIES OF THE UNDER SECRETARY FOR HEALTH**

The Under Secretary for Health, or designee, is responsible for:

- a. Ensuring a safe and healthful working environment for VHA employees and volunteers.
- b. Implementing OSH requirements contained in Federal laws and regulations, E.Os., VA and VHA Directives and Handbooks, and OSH articles of collective bargaining agreements.

c. Promoting and ensuring the implementation of VA Directive 7700, VHA Directive 7701, and VHA Handbook 7701.01.

d. Establishing OSH performance standards for management officials in program offices under the Under Secretary for Health's supervision.

e. Developing VHA policy and programs to address safety and health issues.

f. Ensuring OSH technical support and services to VHA offices located in the VISN, but outside of the authority of VISNs (e.g., CMOPs) by establishing both national and VISN Memoranda of Understanding (MOUs).

g. Ensuring OSH technical support and services to VA Offices and Administrations (e.g., Veteran Benefits Administration (VBA) Offices and National Cemetery Administration (NCA)) located within the VISN by establishing both national and VISN MOUs.

h. Issuing policy regarding the OSH elements for non-VHA agency employees (Office of Information Technology, Consolidated Contracting Activity, VBA, Veterans Canteen Service (VCS)) working in VHA workplaces or on VHA property.

i. Ensuring VHA programs and construction designs and specifications comply with OSH requirements.

j. Ensuring adequate staffing and funding to implement and maintain the VHA OSH Program.

k. Recognizing significant contributions to the VHA OSH Program through special awards.

l. Ensuring that the VHA Directive 7701 and VHA Handbook 7701.01 are reviewed and updated every 3 years, in accordance with the VA Safety Strategic Plan (SSP).

m. Establishing and supporting a VHA Safety and Health Leadership Committee. *NOTE: The facility Safety and Health Leadership Committee is not intended to meet the requirements of 29 CFR 1960.36(b).*

## **7. RESPONSIBILITIES OF THE DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT**

The Deputy Under Secretary for Health for Operations and Management (10N) is responsible for:

a. Ensuring that VISNs provide OSH support to assigned VHA facilities;

b. Establishing the Office of Safety, Health, Environmental and Emergency Management (10NS) as the program office for the VHA OSH Program.

c. Conducting an annual review of the VHA OSH Program. This review is the basis of the annual report submitted to the VA Director, OSH. The report must be submitted by the date specified by the Designated Agency Safety and Health Official (DASHO).

d. Establishing the VHA Safety and Health Leadership Committee (see par. 11).

## **8. RESPONSIBILITIES OF THE DIRECTOR, SAFETY HEALTH, ENVIRONMENTAL AND EMERGENCY MANAGEMENT**

The Director, Safety Health, Environmental and Emergency Management is responsible for:

a. Serving as the VHA DASHO.

b. Representing VHA on the VA's Safety Steering Committee and appointing an alternate representative to attend the Committee meetings, as needed.

c. Developing and implementing VHA OSH Programs in coordination with the Deputy Under Secretary for Health for Operations and Management; VISN officials; VHA facility directors; the Chief Consultant Occupational Health, Safety, and Prevention Strategic Healthcare Group; and Union representatives.

d. Overseeing and directing the operations of the Center for Engineering and Occupational Safety and Health (CEOSH).

e. Establishing goals and objectives for OSH programs and initiatives.

f. Serving as the Deputy Under Secretary for Health for Operations and Management's liaison to the DASHO, through the VA OSH Office, and to Administration Managers, Assistant Secretaries, and other government officials.

g. Serving as the Chairperson of the VHA Safety and Health Leadership Committee.

h. Analyzing VHA injury, illness, and incident data.

i. Developing periodic reports to the VHA Service Support Center (VSSC) and the VHA annual report.

j. Ensuring the employee's right to report unsafe and unhealthful working conditions without reprisal.

k. Administering the VHA OSH Awards Program. Awards are to be presented annually to those VHA organizations or individuals that have made outstanding contributions in the development or implementation of the OSH Program. *NOTE: The National Safety and Health Leadership Committee coordinates and develops the selection criteria, award categories and levels, and the program's nomination process.*

l. Appointing a group to develop a charter and a Strategic Plan for the VHA Safety and Health Leadership Committee (see par. 11).

m. Developing OSH training initiatives for all VHA employees based on:

(1) Recommendations from the VHA Safety and Health Leadership Committee,

(2) An analysis of accident and injury trends,

(3) Federal and state regulatory actions, and

(4) Recognized best practices and recommendations.

**9. RESPONSIBILITIES OF THE DIRECTOR OF OCCUPATIONAL HEALTH, SAFETY, AND PREVENTION STRATEGIC HEALTH CARE GROUP (13D)**

The Director Occupational Health, Safety, and Prevention Strategic Health Care Group is responsible for:

a. Assisting and advising the Deputy Under Secretary for Health for Operations and Management and Director, Safety, Health, Environmental and Emergency Management, on VHA occupational and environmental health policies and programs.

b. Communicating regularly with the Director, Safety, Health, Environmental and Emergency Management on occupational health issues and initiatives.

c. Providing quarterly updates on the occupational health program to the Safety and Health Leadership Committee.

d. Providing program planning and coordination with Federal and private sector agencies and institutions relating to occupational health issues.

e. Implementing and managing the VHA Medical Surveillance Program.

f. Developing and coordinating clinical occupational health policy and issues regarding safety, industrial hygiene, infection control, worker compensation, and clinical services.

g. Coordinating and providing resources for occupational and environmental health educational programs, conducting legislation review, and submitting comments to Federal and state agencies, and to the Director of Safety, Health, Environmental and Emergency Management.

h. Implementing and managing a recordkeeping system for the VHA Medical Surveillance Program.

## 10. RESPONSIBILITIES OF THE CHIEF OF HEALTH CARE ENGINEERING

The Chief of Health Care Engineering (10NE) is responsible for:

- a. Providing design and specifications for VHA projects to appropriate VISN personnel for review and comment.
- b. Ensuring the Resident Engineer maintains contract submittals related to OSH programs, including contractor safety programs, product inventories, performance tests and certifications, and Material Safety Data Sheets for hazardous chemicals.
- c. Ensuring the Resident Engineer informs contractors of existing potential hazards they may encounter in the VHA work environment.
- d. Notifying OSH personnel when newly constructed and remodeled space is ready for a pre-occupancy inspection.
- e. Including safety and health personnel on the distribution list of directives and information letters related to safety.

## 11. VHA SAFETY AND HEALTH LEADERSHIP COMMITTEE

a. The VHA Safety and Health Leadership Committee provides:

- (1) Advice and recommendations to VHA's Director of Safety, Health, Environmental and Emergency Management on methods and procedures leading to effective occupational safety and health management.
- (2) A forum to request assistance for program development and implementation, data collection, and technical assistance.
- (3) Recommendations for OSH training.
- (4) A forum to review and recommend nominations for VHA national safety and health awards.

b. It includes, at a minimum:

- (1) A Chairperson, who is the Director of Safety, Health, Environmental and Emergency Management;
- (2) A Safety Manager, Occupational Safety and Health Specialist, or an Industrial Hygienist from the Office of the Director of Safety, Health, Environmental and Emergency Management;
- (3) The Safety, Environmental, Emergency Advisory Board (SEEAB) Chairperson;

(4) The Director of Occupational Health, Safety, and Prevention Strategic Health Care Group;

(5) A CEOSH Representative;

(6) A VISN Occupational Safety Manager;

(7) A VISN Industrial Hygienist;

(8) A facility Occupational Safety Manager;

(9) A facility Industrial Hygienist; and

(10) One representative from each National Union.

c. The committee membership must include one representative from each of the National Unions, to be designated by the Unions. *NOTE: The facility Safety and Health Leadership Committee is not intended to meet the requirements of 29 CFR 1960.36(b).*

## 12. RESPONSIBILITIES OF THE VISN DIRECTOR

The VISN Director is responsible for:

a. Submitting a written OSH Program to the Deputy Under Secretary for Health for Operations and Management. This written program must define the following elements and responsibilities: *NOTE: Changes in program scope and staffing must obtain the Deputy Under Secretary for Health for Operations and Management approval prior to implementation.*

(1) The VISN Director's role in the OSH Program.

(2) Ensuring that VISN Safety and Health professionals evaluate the training needs of facility safety and health staff during the Annual Workplace Evaluation (AWE).

(3) VISN OSH Program staffing. The VISN OSH Program consists, at a minimum, of:

(a) One VISN Occupational Safety Professional, and

(b) One VISN Industrial Hygienist.

*NOTE: The intent of this policy is to establish an OSH Program. Collateral duties assigned to Safety and Industrial Hygiene staff need to be kept to a minimum and need to be limited so it does not interfere with their primary responsibility.*

(4) Developing a charter for the Safety and Health Leadership Committee, scheduling meetings, at least quarterly, and appointing committee members. (see par. 13).

(5) Designating the members of the Board of Inquiry and directing the work of the Board.  
*NOTE: Facilities may conduct Boards of Inquiry for serious occupational safety and health events which do not meet the VISN notification requirements.*

(6) Ensuring a Board of Inquiry investigates any work-related fatality; in-patient hospitalization of three or more employees; overexposure of facility personnel to radiation; and fires resulting in serious injury, death, or damages exceeding \$10,000.

(a) Upon notification of such an event, the VISN Director is responsible for appointing a Chairperson to oversee a Board of Inquiry.

(b) The Board must submit a descriptive report, including all elements required in 29 CFR 1960.29, to the VISN Director, the Facility Director, the facility Union representative, and the Deputy Under Secretary for Health for Operations and Management within 30 days of the event.

(c) If more than 30 days is needed, an extension must be requested from the Director of Safety, Health, Environmental and Emergency Management.

(d) The investigative report must be made available to the DASHO within 15 days after receipt of the report by the Deputy Under Secretary for Health for Operations and Management.

(e) The report must be provided to the Assistant Secretary of Labor, or authorized representative, upon request. *NOTE: The Office of the Assistant Secretary of Labor had oversight of all Government OSHA activities.*

(f) VHA facility officials must verify and notify the VISN Director, Union representative, and appropriate regulatory agency of any event which may warrant a VISN Board of Inquiry within 8 hours of discovery (as soon as possible is best). Events which must be reported to the VISN include:

1. Work-related fatalities.
2. Incidents resulting in the in-patient hospitalization of three or more persons.
3. Fires resulting in serious injury, death, or exceeding \$10,000 in damages.
4. An overexposure to radiation event.

(7) Notifying the Deputy Under Secretary for Health for Operations and Management immediately upon confirmation of any event that requires a Board of Inquiry. The Deputy Under Secretary for Health for Operations and Management must inform the DASHO of any event involving an employee death or inpatient hospitalization of three or more employees as soon as possible after the notification is received from the VISN by the Deputy Under Secretary for Health for Operations and Management office.

(8) Coordinating the collection of facility information for the Annual Safety and Health Report, as required by 29 CFR 1960.78(b).

(a) The report must include a performance summary and initiatives of the VISN OSH Program.

(b) Information to be included in the report is specified by the Director of Safety, Health, Environmental and Emergency Management.

(c) Reports must be submitted to the Deputy Under Secretary for Health for Operations and Management upon request by the Director of Safety, Health, Environmental and Emergency Management.

(9) Ensuring a qualified VISN-level team, consisting of at least one Industrial Hygienist and one Safety Manager conducts an annual OSH compliance inspection and program evaluation for all assigned VHA medical centers. Industrial Hygiene and Safety evaluations may be conducted concurrently or separately.

(a) Ancillary facilities may be evaluated by one qualified VISN-level Industrial Hygienist or Safety Manager, or may be assigned to qualified medical center safety staff. VISN OSH personnel must review annual evaluations of ancillary facilities and pre-occupancy inspections conducted by VHA facility staff.

(b) The emphasis of the AWE is occupational safety and health. If the facility requires a survey of programs in addition to safety and health, it cannot interfere with the conduct and purpose of the occupational safety and health evaluation.

(c) The AWE evaluation report must be reviewed and signed.

(d) The VHA Facility Director must receive VA Form 2165, Safety, Occupational Health and Fire Protection Evaluation, within 15 working days after the closing conference for safety violations and 30 working days after the closing conference for occupational health violations.

(e) The Safety Automated Facility Evaluation (SAFE) Technical Deficiencies List must be used to report all other deficiencies.

(10) Developing and implementing a policy to ensure the rights of employees to file reports of unsafe or unhealthful working conditions including the right to file anonymous reports and the prohibition of reprisal, must include all elements required by 29 CFR 1960.28.

(11) Ensuring there is an investigation of employee reports of unsafe or unhealthful working conditions.

(a) VISN OSH staff is responsible for investigating all reports of unsafe or unhealthful working conditions that cannot be resolved at the facility level.

(b) The VISN OSH Office maintains a documented list of reports investigated, including action taken to resolve the report.

(12) Participating in the VISN OSH Awards Program

(13) Providing OSH technical support and services to VHA Offices located within the VISN, but not under the control of the VISN (e.g. CMOP), VA Offices and Administrations (e.g. Veterans Benefits Administration (VBA), NCA) located within the VISN, in accordance with established MOUs.

(a) A MOU must be established between the VISN and VHA Offices not under the control of the VISN, including VA Offices and Administrations requesting OSH support. The MOU must specify:

1. The services required by the Office or Administration.
2. Remuneration to the VISN required for OSH services. The compensation for services prevents negative financial and staffing impacts on the VHA safety and health program.

(b) No services are provided to VHA Offices outside of the authority of the VISN, including VA Offices or Administrations outside of VHA, without a current VISN MOU.

### 13. VISN SAFETY AND HEALTH LEADERSHIP COMMITTEE

The VISN Safety and Health Leadership Committee serves as an advisory group for VISN management and assists in the evaluation of the VISN OSH Program; it:

- a. Ensures the Committee meets at regularly scheduled intervals, at least quarterly.
- b. Ensures Committee members are appointed, to include, at a minimum:
  - (1) A Medical Center Director or Associate Director as Chairperson,
  - (2) VISN Occupational Safety and Industrial Hygiene personnel,
  - (3) Facility OSH personnel, and
  - (4) Representatives from the National Unions represented within the VISN (to be appointed by the Union). *NOTE: Other personnel can be invited on an "ad hoc" basis.*
- c. Reports to the Executive Leadership Council or Board.
- d. Recommends implementation plans for the OSH Program goals and policies.
- e. Monitors progress toward implementing the VHA Strategic Safety Plan.
- f. Reviews and recommends OSH training needs.
- g. Discusses local issues that have VISN-wide impact.

- h. Administers the VISN OSH awards programs, to include the selection of award criteria determining the award categories and levels, and the program's nomination process.
- i. Analyzes OSH Program information and data.

*NOTE: The VISN Safety and Health Leadership Committee is not intended to meet the requirements of 29 CFR 1960.36(b).*

#### **14. RESPONSIBILITIES OF THE FACILITY DIRECTOR**

Each facility Director is responsible for:

- a. Ensuring compliance with OSH requirements contained in Federal laws and regulations, E.O.s, VA and VHA Directives and Handbooks, and OSH articles of collective bargaining agreements.

- b. Developing plans to achieve OSH policies and goals established by the VISN Director.

- c. Ensuring adequate staffing, training, resources and funding to implement effective programs in accordance with VA, VHA, OSHA, and TIC requirements.

- d. Ensuring facility construction and maintenance projects, designs, and specifications comply with OSHA, VA, VHA, and VISN OSH requirements.

- e. Ensuring effective investigation of injuries and illnesses and submittal of employee Incident Reports by supervisory personnel within 72 hours of notification of the incident.

- f. Affording employees working at non-VHA facilities protection that is equal to the VHA OSH Program.

- g. Adequately funding the OSH Program.

- h. Including employee representatives in the OSH Program administration by ensuring that official time is granted to the designated local facility safety and health Union representative to attend:

- (1) Scheduled workplace OSH inspections,

- (2) Unscheduled safety and health inspections conducted by VISN or regulatory agencies,

- (3) Union safety conference calls, and

- (4) Safety Committee meetings.

- i. Providing resources and encouraging the participation of staff and Union representatives in local Federal Safety and Health Councils.

- j. Coordinating facility OSH personnel and Resident Engineer operations to ensure safe contractor work practices and OSHA project compliance.
- k. Requiring the coordination of facility OSH personnel and Engineering Contracting Officer's Technical Representatives (COTRs) to ensure safe contractor work practices and OSHA project compliance.
- l. Requiring preoccupancy inspections of any newly-constructed, renovated, or leased spaces prior to occupancy by VHA employees.
- m. Providing periodic review of the facility OSH Program to ensure compliance with applicable Federal standards, E.O.s, and VA and VHA policy.
- n. Participating in the facility AWE by attending the opening and closing conferences, reviewing the AWE report, reviewing and approving initial and follow-up abatement reports, and ensuring correction of deficiencies cited as a result of the AWE; this includes:
  - (1) Ensuring Union participation. Upon management's receipt of the AWE notification, the Director must provide written or electronic notice to all facility local Union presidents of the date and ensure that the designated Union safety representatives are released from duty to attend all aspects of the evaluation.
    - (a) If no employee is selected to attend the AWE, the Union president must submit a written or electronic notice to the Director.
    - (b) The Director must provide copies of the AWE report, the abatement plan, and all follow-up reports to the Unions.
  - (2) Ensuring, that upon receipt of the AWE report, a Notice citing the OSHA deficiencies is posted at, or near, each place an unsafe or unhealthful working condition exists or existed. If it is not possible to post the Notice at or near each location, the Notice must be posted in a prominent place where it will be readily observable by all affected employees. This Notice must remain posted until the condition is abated or for 3 days, whichever is longer.
  - (3) Ensuring the SAFE software program is used to document medical facility evaluation findings.
  - (4) Ensuring the VISN Director receives an abatement plan from the VHA facility within 30 calendar days following the evaluation report. The VISN Director, or designee, must review and approve these corrective actions and abatement plans. *NOTE: Follow-up inspection is at the VISN Director's discretion.*
- o. Completing Safety and Health Management training.
- p. Establishing a system ensuring effective management of programs including, but not limited to: compliance training, medical surveillance, personal protective equipment, engineering controls, and the maintenance and retention of OSHA required records.

q. Establishing a facility-level self-evaluation process for annual program evaluations that is separate from the AWE process.

r. Posting the VA Occupational Safety and Health OSHA Poster (VA 2180), Occupational Safety and Health Protection for VA Employees.

s. Establishing the Accident Review Board (ARB) and ensuring the members are trained in the requirements of the Privacy Act.

t. Ensuring compliance with Federal and state regulations.

u. Ensuring VHA supervisors are accountable for program compliance by:

(1) Enforcing OSH policy and standards within their assigned work area.

(2) Completing required Supervisor Safety training and ensuring the completion of all required training for employees under their supervision.

(3) Evaluating the hazards of each job in their assigned work area.

(4) Identifying and reporting unsafe and unhealthful workplace conditions and initiating corrective action, as appropriate.

(5) Training employees to use safe work practices and to making suggestions for improving the OSH Program.

(6) Correcting employees demonstrating unsafe work practices and initiating re-training.

(7) Reporting and initiating an investigation of employee workplace injuries and illnesses and facilitating employees receiving prompt and appropriate medical attention.

(8) Completing Incident Reports using Automated Safety Incident and Surveillance Tracking System (ASISTS) within 3 days of notice of injury or illness.

(9) Ensuring employees receive OSH training in the recognition of workplace hazards, safe work practices, and the use of personal protective equipment.

(10) Providing material safety data sheets and approved personal protective equipment for hazardous work processes.

(11) Releasing employees for scheduled medical surveillance.

(12) Releasing employees to attend required safety and health training.

(13) Notifying facility management of any employee fatality, and any inpatient hospitalization of three or more employees, including contractors' employees. Notification must

be provided as soon as possible, but no later than 30 minutes after the discovery of the incident by any employee.

(14) Ensuring employees are aware they are to:

(a) Follow safe work practices and use engineering controls and personal protective equipment properly.

(b) Report unsafe or unhealthful workplace conditions to supervisors, the safety office, or a Union representative, and initiate corrective action where appropriate.

(c) Report work-related injuries and illnesses to supervisors.

(d) Complete assigned medical surveillance and training requirements.

(15) Developing and implementing a written OSH Program addressing the responsibilities of the VHA Facility Director and program implementation.

(16) Ensuring the facility Safety and Health Leadership Committee provides assistance and support to Union representatives, management, and employees (see par. 15).

(17) Establishing the ARB (see par. 16).

(18) Ensuring OSH Hazard Surveillance Surveys are conducted and documented by qualified personnel trained in the recognition of occupational safety and health hazards and unsafe work practices in all patient and non-patient care areas of the facility bi-annually.

(a) Surveys must consist of an inspection and a written record of the inspection and abatement.

(b) Inspection sites and frequency of inspections are based on the potential hazard, Agency policy, and regulatory and accreditation standards.

(c) Union attendance must be in accordance with national and local collective bargaining unit agreements. Unions must receive copies of the inspection and abatement records, when requested.

(d) OSH personnel, who develop or review and approve the abatement plan, are to consider input from supervisors, employees, and Union representatives.

(19) Ensuring investigations are conducted for all work-related injuries, illnesses, and accidents by the supervisors responsible for the employee and work area.

(a) The ASISTS software program must be used to document and track all employee injuries and illnesses.

(b) The Annual Summary of Injuries and Illnesses (OSHA 300-A) must be certified by the facility Director and posted from February 1 to April 30 of the following year.

(20) Ensuring unsafe or unhealthful working conditions are reported immediately. *NOTE: Employees are encouraged to report unsafe or unhealthful working conditions to their supervisor.*

(a) If an employee is uncomfortable with discussing the unsafe or unhealthful working condition with the supervisor, or considers the corrective action or implementation schedule inadequate, the employee may notify facility OSH personnel or the Union representative.

1. Employees are encouraged to submit notifications in writing. Any request to remain anonymous must be clearly stated.

2. The employee must be notified in writing within 15 days if a hazard investigation is not warranted, otherwise, for:

a. Employee reports of imminent danger conditions, an inspection must be conducted immediately;

b. Potentially serious conditions, an inspection must be conducted as soon as possible, but within 3 working days; and

c. Other than serious safety and health conditions, an inspection must be conducted within 10 working days.

3. If the employee is not satisfied with the timeliness or response of the facility management team, the employee is encouraged to contact the official responsible for the OSH Program management at the next higher organizational level, as noted on VA Form 2180, VA Occupational Safety and Health Poster.

4. The employee may contact OSHA concerning unsafe or unhealthful working conditions at any time without reprisal. However, the employee is encouraged to work within VHA to resolve the condition.

5. Final investigative reports are to be made available to the employee within 15 days after the completion of the investigation.

(b) Reprisal against employees who exercise their rights under the OSH Program is prohibited.

(c) A record of all formal reports of unsafe and unhealthful working conditions must be reported on VA Form 2169, Request for Inspection of Workplace, and be maintained in the facility OSH Office..

(d) VA Form 2180, must be posted conspicuously in areas accessible to each employee.

*NOTE: Facilities are encouraged to post electronic posters on the facility Web page.*

(21) Ensuring awards are presented annually to those VHA organizations and individuals that actively participated in or have made outstanding contributions in the development or implementation of the OSH Program (see par. 15).

(22) Ensuring compliance with Federal and state regulations.

(23) Ensuring appropriate training for employees assigned responsibilities for development and implementation of the OSH Program (see par. 17).

## **15. FACILITY SAFETY AND HEALTH LEADERSHIP COMMITTEE**

The facility Safety and Health Leadership Committee provides assistance and support to the facility Director, Union representatives, management, and employees. The Committee serves as the focal point for facility-wide safety and health management issues; it ensures OSH-related problems and deficiencies are tracked and resolved in a timely manner.

a. The Committee meets on a monthly basis, monitoring the facility OSH Program and coordinating between services to ensure that OSH Program elements are implemented effectively and efficiently.

b. Committee meeting minutes are provided to committee members and service chiefs.

*NOTE: Employees are provided copies upon request.*

c. A top management official with authority to make programmatic decisions serves as the Chairperson.

d. Committee membership includes a chairperson, facility OSH personnel, Union representatives, supervisors, and other employees that are not official Union representatives.

*NOTE: If another committee is used to fulfill this requirement, it must fulfill all of the duties required of the Safety and Health Leadership Committee.*

e. The Committee reports directly to the Executive Leadership Committee, not indirectly through another committee or council. *NOTE: The facility Safety and Health Leadership Committee is not intended to meet the requirements of 29 CFR 1960.36(b).*

f. The Committee is responsible for ensuring the development of the selection criteria for the annual award program, for determining the award categories and levels, and establishing the program's nomination process.

## **16. ACCIDENT REVIEW BOARD (ARB)**

a. The ARB, established by the facility Director, must include senior VHA facility management, employee representatives, and representatives from VHA facility programs. These individuals are responsible for occupational safety and health, occupational health, infection control, workers compensation, human resources, and representatives from the affected services.

b. The facility Director must ensure:

(1) A member of senior management is empowered to act as the ARB Chairperson.

(2) That members of the ARB are trained in the requirements of the Privacy Act, to include, at a minimum, the following topics:

(a) An overview of existing Federal privacy laws and regulations (e.g., Privacy Act of 1974, Title 38 United States Code (U.S.C.) 5701; 38 U.S.C. 7332).

(b) Specific VHA facility policy, if any, covering Privacy Act issues.

(c) Penalties for unlawful disclosure of records covered by the Privacy Act.

c. The ARB is responsible for:

(1) Using ASISTS data to support the review of occupational injury and illness incidents. All personal identifiers must be removed prior to review. Incident Reports are made available to the ARB for use in evaluating the causes of employee injuries and illnesses.

(2) At a minimum, reviewing incidents of occupational injury and illness that result in: medical expense, job transfers, restrictions, days away from work, or in lost time beyond the day of incident.

(3) Tracking and trending all illnesses and injuries to provide information for improving the safety and health program.

(4) Reviewing incidents on the basis of elevated frequencies by groupings (e.g., type or source of incident, type of injury, location of incident, job category; and severity of injuries, illnesses, and incidents) and costs (e.g., medical, continuation of pay, wages, and associated costs).

(5) Ensuring that information provided to an ARB member, in reviewing individual incidents of occupational injury and illness, is provided as a routine use under the provisions of the Veterans Health Information System and Technology Architecture (VistA) System of Records and the Privacy Act of 1974. All personally identifiable information discussed in the ARB falls under the Privacy Act of 1974.

## 17. TRAINING

The facility Director, or designee, must ensure training for the following employees who have been assigned responsibilities for development and implementation of the OSH Program:

a. **Administrators.** In this case, training must address the roles of management officials in the VHA OSH Program. Administrators must ensure that each level of management is oriented and trained in their responsibilities under the OSH Program.

b. **Supervisors.** In this case, training must include supervisory responsibilities in the VHA OSH Program. All supervisors must complete the Web based VHA Supervisor Safety Training program offered in the Employee Education System (EES) Learning Management System (LMS).

c. **Employees.** In this case, appropriate employees must receive training and periodic updates in accordance with all Program requirements, including specialized safety, health, and fire protection training appropriate to the work performed by the employee. *NOTE: VISN Safety and Health professionals evaluate the need for existing employees to attend Basic and Intermediate training and recommend necessary courses.*

(1) Career development programs must be implemented for all OSH Program professionals to enable them to meet program needs and maintain professional competencies. Basic and Intermediate Safety training is provided by VHA EES.

(2) All Safety and Health employees newly hired into the VHA system must complete the VHA Basic Safety training at the next available course and Intermediate Safety training within 1 year following completion of the Basic Safety course. *NOTE: Newly-assigned personnel may have more intensive training needs and may be required to complete additional training.*

(3) In the case of collateral duty personnel, training must be provided within 6 months of the appointment of an employee to a collateral duty position or to an OSH Program Committee, the training is to be commensurate with the scope of the employee's assigned responsibilities.

d. **Union Safety Representatives.** In this case, training must be provided to Union safety representatives to enable those representatives to assist in the implementation and administration of the OSH Program and advocate for safety and health in the workplace. Training must include VHA Basic Union Safety training and Intermediate Union Safety training, usually offered by EES. Official time and travel funding must be provided for this training. If the facility chooses to conduct training at the facility site, they must use qualified instructors and follow the agenda developed for the VHA courses.

## 18. REFERENCES

- a. E.O. 12196, Occupational Safety and Health Programs for Federal Employees.
- b. OSHA Publication 2014, Recordkeeping and Reporting Guidelines for Federal Agencies.
- c. Pub. L. 91-596, the Occupational Safety and Health Act of 1970, Section 19.
- d. Title 29 CFR, Part 1960, Basic Program Elements for Federal Employee OSH Programs and Related Matters.
- e. VA Directive 7700, Occupational Safety and Health Program.
- f. Negotiated Collective Bargaining Unit Agreements.

**Department of  
Veterans Affairs**

# Memorandum

**OCT 26 2009**

**Date:**

**From:** Deputy Under Secretary for Health for Operations and Management (DUSHOM) (10N)

**Subj:** Clarification of Organizational Responsibilities Related to Sterile Processing and Distribution (SPD) and Processing Reusable Medical Equipment (RME) (WebCIMS 442132)

**To:** Network Directors (10N1-23)

1. Reference VHA Directive 2009-031, Improving Safety in the Use of Reusable Medical Equipment through Standardization of Organizational Structure and Reprocessing Requirements, dated June 26, 2009. Since issuance of that Directive, there has been ambiguity in defining responsibilities for SPD oversight, processing of RME, and defining core logistics responsibilities. This Memorandum clarifies these responsibilities and ambiguities.

2. The following functions are not considered to be core logistics responsibilities and have been defined as core clinical responsibilities relative to SPD and RME processing.

a. Oversight of all sterile processing activities shall be the responsibility of the Chief of SPD (or equivalent), regardless of where the processing occurs.

b. Supervision of the SPD operations (including but not limited to RME processing) shall be under the direct organizational control of the facility's Nurse Executive. This includes:

- Development of training programs, standard operating procedures, certification of competencies, and related quality control programs related to SPD operations and RME processing.
- Providing input into any decision that may impact SPD-related functions or support.
- Input regarding facility construction contracts that may impact where medical equipment is used or processed or where supplies are to be stored.
- Input into equipment investment decision making for any SPD related equipment.

c. Physical distribution of consumable supplies within SPD operations or where processing of RME occurs shall be the responsibility of SPD staff.

3. Core logistics functions as they relate to SPD and RME processing functions are identified below. Those responsibilities shall remain under the control of the facility logistics organization and shall not be assumed by or transferred to the Chief of SPD or Nurse Executive at the facility.

a. Inventory Management of Consumable Medical/Surgical, Radiology, Laboratory, Dental and Facilities Management Supplies:

- Requisitioning and ordering consumable supplies, including those used in support of the activities and functions noted above. This includes all bar-coding, related bar-code scanning (in the warehouse and inventory primary and secondary locations), order processing (in GIP and IFCAP), and adjustments to inventory levels as a result of an order or receipt.
- Receiving and storage of all consumable supplies from delivery at the medical center by suppliers, vendors and contractors to distribution of those supplies to inventory primary locations.
- Distribution of all consumable supplies from a central warehouse/receiving location to inventory primaries and secondary's throughout the medical center, with the exception of consumable supplies specifically in support of SPD operations.

b. Equipment Management:

- Preparing requisitions and orders (within delegated authority) for capital and non-capital equipment.
- Receiving capital and non-capital equipment, processing related payments and data entry into appropriate systems.
- Oversight and managing of the tracking, physical inventorying, reporting and dispositioning of all capital and non-capital equipment. This includes related data management, reporting, and training of custodial officials.

4. The aforementioned clarification is consistent with VHA Directive 2009-031 and anticipates further standardization of core logistics functions across all networks and medical centers.

  
William Schoenfeld, FACHE

cc: CLOs (10N1-23)

**Supplemental Clarification of Organizational Responsibilities**  
**Related to Logistics and Sterile Processing & Distribution (SPD)**  
**of Reusable Medical Equipment (RME)**  
**As Originally Defined in the**  
**VHACO DUSHOM Memorandum Issued October 26, 2009**

1. Background:

- a. The October 26, 2009 DUSHOM Memo provided general guidance regarding the division of responsibilities for Reusable Medical Equipment (RME) processing and organizational alignment and control of Sterile Processing & Distribution (SPD) functions as they relate to RME processing. That Memo was issued following issuance of VHA Directive 2009-031 (Processing of Reusable Medical Equipment on June 26, 2009).
- b. The aforementioned DUSHOM Memo and VHA Directive 2009-031 are consistent in their intent for Logistics and SPD functions and organizational responsibilities. While previous guidance gave facility Directors a choice on the organizational alignment of the "distribution" function of what was defined as Sterile Processing and Distribution, the inconsistent implementation nationally and across networks does not fully support the inventory management functions inherent in Logistics. Consistent with both the DUSHOM Memo and VHA Directive 2009-031, all future references to SPD shall reflect the fact that SPD stands for Sterile Processing and Decontamination.
- c. Both the DUSHOM Memo and VHA Directive are consistent with the need for greater consistency and standardization of Logistics and SPD/RME functions and associated organizational alignment of both.
- d. References below to consumable supplies do not include any supplies or inventory associated with Prosthetics, Pharmacy or Nutrition & Food Service.
- e. The Supplemental Clarification provided below is provided as a tool to facilitate that standardization, regardless of how individual medical centers and/or networks currently define those responsibilities.

**2. Responsibilities Defined - Specific:**

**a. Nurse Executive – SPD/RME Operations (Facility Level):**

- i. Oversight and organizational responsibility of all sterile processing “production” activities. Production in this context includes all handling and processing of RME (sterile instrument sets, pumps, scopes, etc.), following its use with or on a patient, through cleaning/decontamination/sterilization, and ending with packaging and re-distribution of the RME for re-use by using services.
- ii. Chief of SPD reports to Nurse Executive (NE).
- iii. Development, implementation and management of RME Standard Operating Procedures (SOPs).
- iv. Development, deployment and management of all SPD training programs.
- v. Development, deployment and management of RME competencies.
- vi. Ensuring that input is made into any decision that may impact SPD-related functions, support or operations.
- vii. Ensuring that input is made regarding any facility construction contract that may impact where medical equipment is used.
- viii. Ensuring that input is made into any decision regarding facility construction contracts that may impact where medical supplies are to be stored.
- ix. Ensuring that input is made into equipment investment decision making for any SPD-related equipment.
- x. Physical distribution of consumable supplies related to SPD RME operations from an established secondary to point of use shall be the responsibility of SPD. (Distribution of any/all consumable supplies from a central storage area to an inventory primary, or from an inventory primary to a secondary shall be the sole responsibility of facility logistics staff).

**b. Facility Level Logistics Operations – The facility logistics manager (or equivalent) shall report to the Facility Associate Director for Operations/Management (or equivalent) and shall be responsible for the following:**

- i. Requisitioning/ordering of consumable supplies, including Med/Surg, Radiology, Lab, Dental, Engineering, and Environmental primaries and organizational components that use these supplies. This includes the following:
  1. Bar-coding of all supplies, stocking areas, etc.
  2. Bar-code scanning of all primary and secondary locations.
  3. Order processing in GIP and IFCAP.
  4. Adjustments to inventory levels resulting from ordering, receipt, issuance and usage.

- ii. Receipt and storage of all consumable supplies for the primaries listed in Item b.i. above.
- iii. Distribution of all consumable supplies (for the primaries listed in Item b.i. above) from receipt at a medical center to a central warehouse operation (or equivalent), to a GIP inventory primary (or equivalent), and to a GIP inventory secondary (or equivalent). This includes consumable supplies associated with SPD RME operations.
- iv. Processing payments, receipts and related data entry for any supplies ordered by facility logistics operations.
- v. Physical inventorying (including periodic cycle counts) of all consumable supplies at the GIP inventory primary level.
- vi. Preparing requisitions and orders for capital and non-capital equipment.
- vii. Receiving capital and non-capital equipment.
- viii. Processing payments and related data entry into appropriate systems (IFCAP, FMS, AEMS/MERS, etc.) for capital and non-capital equipment.
- ix. Oversight, management and tracking of all capital and non-capital equipment.
- x. Oversight, management and tracking of physical inventorying of all capital and non-capital equipment.
- xi. Reporting, tracking, and management of equipment disposition/disposal for all capital and non-capital equipment
- xii. All data management and related training with regards to capital and non-capital equipment.

### 3. Staffing

- a. It is recognized that the alignment of distribution functions previously aligned under Sterile Processing and Distribution to Logistics may result in realignment of some staff. Depending on the facility, staffing impacts may be relatively minor to very significant. Facilities should consider the following in addressing staffing issues:
  - i. Minimize staffing impacts via:
    - 1. More efficient scheduling of distribution activities – for supply inventories and RME distribution. Detailed evaluation of workload volume (RME, supply inventory), distribution schedules, staff availability, and use of distribution equipment should be done prior to any decision to add staff.

2. Managing inventory levels (e.g., stocking supply secondaries to higher levels) to reduce the number of staff needed for distribution activities.
  3. A combination of 1 and 2 above.
  4. Reconfiguring storage and distribution locations to accomplish the most efficient management of inventory distribution and RME movement.
- ii. Acquiring additional inventory distribution equipment (case carts, etc.) to reduce the recurring cost of adding staff.
  - iii. Position descriptions and associated grades may need to be updated/re-written. It is unlikely (though possible) that down-grading of positions will/should occur. Because most current position descriptions (in logistics and SPD) do not reflect the current complexities, increasing use of technology, higher technical standards and training requirements, and greater interface with vendors and suppliers, segregating SPD and logistics functions should proceed with little or no impact upon grades. In some cases higher grades may be warranted. If position descriptions must be re-written, facilities should coordinate with their Network CLO and Network Nurse Executive as appropriate to facilitate standardization within the network.
- b. Because some facilities provide multiple shift coverage for RME processing within SPD, maximizing staff utilization should be consistent with the aforementioned roles and responsibilities for logistics and SPD staffs. Maximizing staff utilization can be done by a variety of methods, including the following:
- i. Defining using service demand/usage patterns for RME.
  - ii. Evaluating sterile processing throughput for RME (both within dedicated SPD areas as well as areas external to SPD that perform sterile processing).
  - iii. Examining existing staffing levels and productivity for all RME activities to match usage with available staff.
  - iv. Depending on the outcome of the aforementioned analysis, staffing levels and equipment investments can then be furthered explored to address needs.
- c. To the extent that training requirements for affected SPD and Logistics positions do not reflect current organizational realities, position descriptions should be modified to reflect updated training needs. Consultation with Nurse Executives and Network CLOs as well as with VHA Program Offices should be encouraged to ensure consistency.

**4. Summary:**

- a. Because of the lack of standardization in some facilities relative to core logistics operations and SPD/RME, the associated ambiguity will give rise to a variety of questions. In making decisions relative to responsibilities and in conjunction with the specific duties outline above, the following is provided:**
  - i. If an activity is part of the processing of RME – cleaning/decontamination, preparation for cleaning/decontamination, sterilizing, and associated packaging, etc. – it should be under the control of SPD and the NE.**
  - ii. If an activity is associated with other (other than RME) distribution of supplies and equipment and delivery of those supplies and equipment, it should be under the control of facility logistic operations.**

**★ Personal Protective Equipment**

PPE was discussed earlier in this module. It helps to protect you, the environment, and the patients and visitors in the medical center.

**Hand Washing**

Hand washing is the single most important step in preventing cross contamination. You should wash your hands before and after every task, including:

- Before starting work
- Before and after meals or breaks
- After using the bathroom
- After handling soiled items
- Before entering clean areas to handle clean items
- Before going off duty
- Immediately following unanticipated contact with body fluids or chemicals

**Spills**

After a disinfectant is used to clean where infectious material has been spilled or sprayed, the affected area must be allowed to air dry. In the case where a large volume of potentially hazardous material has been spilled, your supervisor and Environmental Management Service should be contacted and appropriate steps taken to reduce further contact to co-workers (wet floor signs, etc.).

**Soiled Materials**

Reusable materials, such as towels, instruments, and equipment, which have come in contact with body fluids, should be handled as little as possible. Place materials in an appropriate moisture-resistant laundry bag and carry them to the proper location for cleaning and decontamination. Be sure to wear personal protective clothing while handling them.

All body fluids and disposable items visibly contaminated with body fluids should be discarded as infectious waste. Infectious waste is any substance deemed to be potentially harmful to personnel or the environment by way of cross contamination.