DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Report to the
Office of Special Counsel
OSC File Number DI-17-4897

Department of Veterans Affairs (VA)
VA Greater Los Angeles Healthcare System
Los Angeles, California

Report Date: May 11, 2018

TRIM 2017-D-2847

Executive Summary

The Under Secretary for Health requested that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the VA Greater Los Angeles Healthcare System (the Medical Center), in Los Angeles, California. [redacted] (the whistleblower), who consented to the release of his name, alleged that employees are engaging in conduct that may constitute violations of laws, rules or regulations, and gross mismanagement and abuse of authority, which may lead to a substantial and specific danger to public health. OMI conducted a site visit to the Medical Center on January 8–11, 2018.

Specific Allegations of the Whistleblower

1. From January 2017 to present, a fly infestation has caused the closure of multiple ORs and cancellation of patient surgeries;
2. Since 2016, sewage water leaks have caused the closure of multiple ORs and cancellation of patient surgeries;
3. From June 2017 to present, ORs have been critically short on surgical supplies;
4. Understaffing, particularly of anesthesiologists and OR nursing staff, has affected the facility's ability to perform emergency surgery during the evenings and on weekends, and has caused OR closures; and
5. The lack of an interventional neuroradiologist and neuropathologist has affected the facility's ability to diagnose and remove spinal and brain tumors.

We **substantiated** allegations when the facts and findings supported that the alleged events or actions took place and **did not substantiate** allegations when the facts and findings showed the allegations were unfounded. We were **not able to substantiate** allegations when the available evidence was not sufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of findings, we make the following conclusions and recommendations.

Conclusions for Allegation 1

- We **substantiate** that from November 2016 through February 2017, the presence of flies in the operating room (OR) caused the closure of multiple ORs and the cancellation of patient surgeries. The OR closures were appropriate to ensure patient safety.

- The Medical Center rescheduled and completed 71 percent of these surgeries within 30 days of being cancelled and 20 percent within 60 days of being cancelled.

- We found no evidence that during this period any patient suffered an adverse outcome due to the presence of flies or the delays caused by surgical cancellations.

- From November 2017 through February 2018, the presence of flies caused the closure of multiple ORs and the cancellation of 40 patient surgeries. The OR closures were appropriate to ensure patient safety. The Medical Center implemented actions in a timely manner to address each sighting and attempted to eliminate the presence of flies in the OR. These actions included extermination, placement of fly lights, consulting with VA Central Office (VACO), and contracting an entomologist and pest controllers. However, at times, the Medical Center's main entrance doors are left open, allowing flies access to the building.

- The Medical Center is not tracking or trending the presence of flies, a practice which could provide valuable information, identifying factors that contribute to the presence of flies in the OR, or timing the flies' presence in the OR.

- Despite the Medical Center's contract with a pest control company, it has the overall responsibility for pest management.

Recommendations to the Medical Center

1. Determine whether any patient whose surgery was cancelled in February 2018, experienced any adverse outcomes due to the delay.

2. Continue to monitor for flies daily and immediately take action to eliminate them; ensure all departments involved in the elimination of flies from the OR are kept informed. Utilize tracking and trending information to assist with remediation efforts.

3. Ensure that the assigned staff members treat drains on a weekly basis and document each treatment.

4. Ensure facility inspections occur on a regularly scheduled basis in all areas of the Medical Center, taking a proactive approach to prevent the presence of flies whenever possible, and react appropriately.

5. Complete a standard operating procedure and educate staff regarding pest prevention and surveillance processes to ensure they understand actions in response to insect sighting.

6. Continue to consult with the VACO pest expert and external pest control sources as needed.

7. Determine whether there are gaps in the interstitial space between the 5th and 6th floors through which flies could access the OR; if found, consider sealing these breaches with a solid barrier such as drywall. Continue the surveillance process for flies in the OR.

8. Ensure the main entrance door sensors remain on and the doors are not left open at any time.

9. Consider air curtains to prevent flying insects from entering the building.

Conclusions for Allegation 2

- We **substantiate** that since 2016, water leaks have caused the closure of multiple ORs and cancellation of patient surgeries. The OR closures were appropriate to ensure patient and staff safety while leaks were repaired.

- We found no evidence that any of the patients whose surgery was cancelled because of leaks in the OR, experienced adverse outcomes as a result of these delays.

- The Medical Center repaired the leaks and is preparing to proactively replace all of the pipes in the interstitial space.

Recommendations to the Medical Center:

10. Continue to monitor for leaks and repair any identified as soon as possible.

11. Continue to take the appropriate measures to ensure patient and staff safety when leaks are discovered and while leaks are repaired.

12. Continue with plans to replace the piping.

Conclusions for Allegation 3

- We **substantiate** that the OR has been short on surgical supplies; however, since August 2017, there have been very few, if any, instances when supplies were not readily available for cases.

- The previous Logistics Service leadership team did not ensure that all supplies were entered in the electronic system for tracking and automatic reorder.

Recommendation to the Medical Center

13. Ensure that the Logistics Service continues to properly track and automatically order supplies as needed.

Conclusions for Allegation 4

- We **do not substantiate** that understaffing, particularly of anesthesiologists and OR nurses, has affected the facility's ability to perform emergency surgery during normal business and weekend, holiday, evening, and night hours. The Medical Center is staffed with two on-call surgical teams who have enabled emergency surgery to continue to occur when needed.

- We **substantiate** that staffing issues have contributed to scheduling and block time changes.

- Based on the volume and complexity of surgical cases performed at the Medical Center and productivity per full-time employee, the Medical Center should fill all Anesthesia provider vacancies, and determine whether the Anesthesia Service needs additional staff.

- Consider the feasibility of using ORs 9 and 10 more frequently in an effort to decrease wait times. This determination should be based on resource needs, including staff, equipment and supplies.

- Because of staff shortages on evening shifts, the day shift nurses are setting up ORs when they arrive for their tour of duty; this could have a negative impact on the efficient use of OR resources, and could reduce the number of cases the OR staff is able to complete.

- The Human Resources (HR) Service's inadequate staffing and inefficient processes has negatively impacted the Medical Center's ability to hire staff for the Anesthesia and other services in a timely manner. The Medical Center is in the process of taking steps to address this concern including working with the VACO Workforce Management team.

- The Anesthesia Service does not have a dedicated Administrative Officer, who would be able to consistently follow up on HR issues, as well as other administrative functions for the Service.

Recommendations to Medical Center:

14. Aggressively recruit for and fill all Anesthesia and Nursing Services' vacancies as soon as possible.

15. Ensure vacancies are posted on USAjobs.com and hiring actions are taken in a timely manner.

16. Utilize available strategies to retain current staff including the Education Debt Reduction Program, recruitment and retention, salary waivers, and other options to improve attractiveness of VA positions.

17. Aggressively recruit for additional HR staff.

18. Provide additional training for current HR staff members, including use of direct hire authorization, use of continuous open listing, and other HR options to increase efficiency of the HR hiring process. Continue the plan to utilize agreement with the VACO Workforce Management team. Once the training has been provided to all HR

staff, assess effectiveness, monitor for compliance, and address noncompliance as indicated.

19. Consider assigning a dedicated Administrative Officer or support staff member to the Anesthesia Service to ensure all issues are addressed, including those of HR.

20. Notify VISN 22 of any critical staffing shortages.

Conclusions for Allegation 5

- We **do not substantiate** that the lack of an interventional neuroradiologist and neuropathologist has affected the facility's ability to diagnose and remove spinal and brain tumors.

- Although we found no evidence of any adverse events related to a lack of interventional neuroradiology services, the lack of a contract arrangement with other facilities for treatment of patients with acute neurovascular disease could lead to significant delays.

- The services of a readily available neuropathologist could help the surgeons make a more informed decision during the removal of certain types of tumors.

Recommendation to the Medical Center:

21. Develop recruitment or sharing agreements with an affiliate or nearby facility to acquire neuroradiology and neuropathology services, given that the Medical Center is classified as capable of providing care for the most complex patient scenarios.

Summary Statement

OMI has developed this report in consultation with other Veterans Health Administration (VHA) and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, the Office of General Counsel has provided a legal review, VHA HR has examined personnel issues to establish accountability, the Office of Accountability and Whistleblower Protection (OAWP) has reviewed the report to determine whether it makes findings against senior leaders requiring OAWP action, and the National Center for Ethics in Health Care has provided a health care ethics review. We found past violations of VA and VHA policy on the part of the Logistics Service, and note that a substantial and specific danger to public health and safety exists at the Medical Center due to water leaks and flies.

Table of Contents

I. Introduction

The Under Secretary for Health requested that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the VA Greater Los Angeles Healthcare System (the Medical Center), in Los Angeles, California. [redacted] (the whistleblower), who consented to the release of his name, alleged that employees are engaging in conduct that may constitute violations of laws, rules or regulations, and gross mismanagement and abuse of authority, which may lead to a substantial and specific danger to public health. OMI conducted a site visit to the Medical Center on January 8–11, 2018.

II. Facility Profile

The Medical Center, part of Veterans Integrated Service Network (VISN) 22, is the largest integrated health care organization in VA. It has an operating budget of over 1 billion dollars and cared for over 88,000 Veterans in 2016. It is a Joint Commission accredited, complexity level 1a facility serving Veterans throughout Kern, Los Angeles, San Luis Obispo, Santa Barbara, and Ventura Counties, and in its outpatient clinics in Gardena, San Gabriel, San Luis Obispo, East Los Angeles, Lancaster, Oxnard, Santa Maria, and Santa Barbara. The Medical Center offers surgical care for over 12 surgical specialties including cardiothoracic and neurosurgery.

III. Specific Allegations of the Whistleblower

1. From January 2017 to present, a fly infestation has caused the closure of multiple ORs and cancellation of patient surgeries;
2. Since 2016, sewage water leaks have caused the closure of multiple ORs and cancellation of patient surgeries;
3. From June 2017 to present, ORs have been critically short on surgical supplies;
4. Understaffing, particularly of anesthesiologists and OR nursing staff, has affected the facility's ability to perform emergency surgery during the evenings and on weekends, and has caused OR closures; and
5. The lack of an interventional neuroradiologist and neuropathologist has affected the facility's ability to diagnose and remove spinal and brain tumors.

IV. Conduct of Investigation

The VA team conducting the investigation consisted of [redacted]., Senior Medical Investigator, [redacted], Clinical Program Manager, both of OMI, joined by [redacted], Compliance Engineer, VA Central Office (VACO) Office of Capital Asset Management, Engineering, and Support (OCAMES), [redacted], Chief of Neurosurgery, VA Connecticut Healthcare System, West Haven, CT, [redacted], Program Manager, Textile Care and Pest Management, Environmental Programs Services, [redacted] VISN 21 Surgical Lead, [redacted], VISN 1 Human Resources (HR) Chief (Virtual), [redacted], Chief of Anesthesia, San

Francisco VA Medical Center, and [redacted], RN, Veterans Health Administration (VHA) National Surgery Office OR Operations and Nursing. We reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A. We toured the Medical Center's OR and associated areas related to the allegations, and held entrance and exit briefings with Medical Center leadership:

- [redacted], Medical Center Director (MCD)
- [redacted], Chief of Staff (CoS)
- [redacted], MS, Associate Director, Patient Care Services (ADPCS)
- [redacted], Executive Director of Clinical Care
- [redacted], Associate Director
- [redacted], Acting Assistant Director
- [redacted] Deputy CoS
- [redacted] Deputy CoS
- [redacted], Health System Specialist (HSS) to MCD
- [redacted], HSS to CoS
- [redacted], HSS to Associate Director
- [redacted], HSS to Executive Director of Clinical Care
- [redacted], HSS to Assistant Director
- [redacted] Chief of Surgery
- [redacted] Chief of Anesthesiology
- [redacted], RN, OR Nurse Manager
- [redacted], Chief, Sterile Processing Service (SPS)
- [redacted], Assistant Chief, Logistics Service
- [redacted] RN, Chief Quality Management (QM)
- [redacted], RN, VISN QM Office (via telephone)
- [redacted], VISN 22 Director (via telephone)

VA initially interviewed the whistleblower via teleconference on December 1, 2017, and in person at the beginning of our site visit on January 8, 2018. We also interviewed the following employees at the Medical Center:

- [redacted], former Acting Chief, Logistic Service
- [redacted], DPM, Chief of Podiatry
- [redacted], RN, OR Nurse
- [redacted], MCD
- [redacted], Chief, SPS
- [redacted] Staff Neurosurgeon
- [redacted] VISN Surgical Consultant
- [redacted], RN, OR Nurse
- [redacted] Associate Chief of Quality
- [redacted], RN, Off-Tour Supervisor
- [redacted] Anesthesiologist
- [redacted] Certified Registered Nurse Anesthetist (CRNA)

- [redacted] RN, VA Surgical Quality Improvement Program (VASQIP) Nurse
- [redacted] RN, OR Nurse
- [redacted] Acting Chief, Environmental Management Service (EMS)
- [redacted] RN, Risk Manager
- [redacted], RN, Nurse Manager
- [redacted], RN, Associate, Patient Care Services
- [redacted] Chief of Pathology
- [redacted] Chief of Vascular Surgery, Deputy Chief of Surgery
- [redacted], HR Specialist
- [redacted] Acting Chief of Neurosurgery
- [redacted] Anesthesiologist
- [redacted] Acting Chief of Radiology
- [redacted] Deputy CoS
- [redacted], Inventory Manager, Logistics Service
- [redacted] RN, Risk Manager
- [redacted] Chief of Surgery
- [redacted], Neurosurgery Chief Resident
- [redacted] HR Specialist
- [redacted] Chief, HR
- [redacted] Chief of Anesthesia
- [redacted], Acting Assistant Chief, QM
- [redacted] Pest Controller
- [redacted], Chief, Facility Management Service and Engineering
- [redacted] CoS
- [redacted], RN, QM
- [redacted] Assistant Chief, Logistics Service
- [redacted] Infection Control

V. Findings, Conclusions, and Recommendations

Allegation 1

From January 2017 to present, a fly infestation has caused the closure of multiple ORs and cancellation of patient surgeries.

Background for Allegations 1 and 2

The OR suite typically consists of individual rooms where operative procedures are performed, as well as areas where sterile supplies are stored and areas where dirty instruments are placed for pick up and reprocessing. The ORs are generally windowless and feature controlled temperature and humidity. Special air handlers filter the air and maintain a slightly elevated pressure to ensure adequate air circulation, and that the sterile air of the OR pushes outward, preventing nonsterile air outside of it from coming in. This environment is expected to be free of pests, including flies, and leaks; the presence of which in the OR must be remediated immediately.

Findings

The Medical Center's OR area consists of 10 operating rooms, 8 of which are contained within the main OR space, along with a supply and reusable equipment storage space. The main ORs, rooms 1–8, are underneath an interstitial space below the dialysis unit. The remaining two rooms, 9 and 10, are in a space adjacent to the main OR and are not under the dialysis unit. These rooms are smaller than the other ORs, but are equipped to be fully functional, and used as needed. During fiscal years (FY) 2015, 2016, and 2017, the OR completed 4,510, 4,253, and 3,991 procedures, respectively. The flies were sighted in the main OR space and corridors outside of the OR rooms.

A. Fly Sightings in the OR November 2016 through September 2017, and Actions Taken

In November 2016, there was a series of nine fly sightings in the main OR area. The Medical Center initiated steps to address the issue, including bringing in a pest control company to perform spot treatments of pesticide, but staff continued to see flies. The Medical Center kept ORs 9 and 10 open for emergency surgeries, and closed ORs 1–8 over a weekend so the pest control expert could perform intense treatments. EMS performed extensive terminal cleaning of the area, which cleaning involves scrubbing and disinfecting all exposed surfaces, including wheels and casters of all equipment, and cleaning and disinfecting the floor with a wet vacuum or single-use mop. This level of cleaning is performed every day after the last scheduled OR patient has received care, or more frequently for special circumstances. Engineering staff members replaced all under-sink plumbing, including a garbage disposal in one of the staff breakrooms, and permanently closed off doors leading into a sterile area within the OR from the staff breakroom and men's locker room. The pest control contractor also placed lights with pheromone traps approved for use in these areas in each OR. After these initial actions, additional flies were again sighted in the main OR space, and Rooms 1–8 were closed again. EMS staff performed extensive cleaning and treated all drains on the 5th floor and those from the dialysis unit. The Medical Center engaged EMS staff and outside pest consultants, including an entomologist, who identified the flies as phorid flies, a species often found around drains, such as infrequently used bathroom sinks and showers. The main risk they pose to humans is exposure to disease and bacteria spread by their physical presence. They are very small, often mistaken for gnats, and due to their size, can squeeze through tiny holes and cracks in buildings; adult females follow air currents and will often fly toward light.

Fly trapping products that utilize a sticky surface may be effective in determining areas of infestation but cannot eliminate the problem. Pesticide sprays will destroy the adults, but are generally not safe for use in a surgical setting. The only effective, long-lasting method of managing this fly is to eliminate all observed and potential breeding sites through the use of thorough sanitation and moisture control. On April 1, 2017, the Medical Center removed the dialysis waste storage tank from the interstitial space above the OR as this was believed to be to a source of phorid flies. Per interviews and associated documentation, this appeared to eliminate the fly problem.

From June through August 2017, no flies were seen in the OR, but in September, OR staff documented four fly sightings of a different species (bottle fly) that was determined to have come from an outpatient unit on the 4th floor, as well as the back dock where large dumpsters and trash compactors are located. This fly species lives in a more open environment and was thought to have entered the building through an entranceway. The Medical Center immediately implemented remediation efforts to eliminate the source of the flies by placing additional fly lights and traps in entranceway areas and by making plans to install air curtains to prevent flies entering the building. In addition, it thoroughly cleaned the trash compactor and surrounding area and replaced recycling containers with new ones.

B. Surgery Case Cancellations and Rescheduling

The Medical Center documented 25 fly sightings in the OR between November 2016 and September 2017, which resulted in the cancellation of 50 surgeries. All Veterans who had their surgery canceled were offered different reschedule dates based on OR availability and patient preference. Most of the surgical cases were elective and non-emergent. The Medical Center adjusted the surgical block time schedule utilizing "Bump Days" (as described later in this report) in order to ensure these Veterans were rescheduled in a timely manner. The Medical Center did not reschedule two of the 50 cases because the patients declined to have their surgery at that time. The Medical Center utilized the Choice Program to reschedule three patients for surgery in a community, non-VA facility, one of which was rescheduled and completed within 40 days of being cancelled and one was rescheduled and completed within 52 days of being cancelled. One patient was rescheduled by the Medical Center within 7 days of being cancelled, but the patient decided to postpone his surgery at that time. Once the patient decided to reschedule his surgery, the Medical Center was unable to reschedule his procedure within the next 30 days, so they referred him to a community provider via the Choice Program; his surgery was completed within 90 days of his referral to the Choice provider. The whistleblower indicated that it is not uncommon for patients to wait 2-3 months for their procedure to be rescheduled after cancellation due to an OR closure. Of the 50 surgeries cancelled because of flies sighted in the OR, the Medical Center rescheduled and completed:

- 32 (71.1 percent) within 30 days of being cancelled;
- 9 (20 percent) within 45 days of being cancelled;
- 2 (4.5 percent) within 60 days of being cancelled;
- 1 (2.2 percent) in more than 90 days but less than 120 days of being cancelled; and
- 1 (2.2 percent) within 120 days of being cancelled.

During this OR closure, the Medical Center transferred one patient to the Long Beach VA Medical Center for urgent care and possible surgery. The patient was treated conservatively and recovered fully without surgery.

In summary, the Medical Center cancelled 50 cases because of fly sightings in the OR. Of these 50, two declined to have their surgery rescheduled and three cases were done by Choice providers in a community, non-VA facility. Of the 45 cases the Medical Center rescheduled and completed, 41 (90.1 percent) were done within 45 days of being cancelled.

C. Adverse Outcomes

In our review of the Medical Center's quality data and the electronic health records (EHR) of the impacted patients, we found no evidence of any adverse patient outcomes related to the presence of flies or the delays caused by surgery cancellations

D. Fly Sightings in the OR October 2017 through February 2018, and Actions Taken

There were no OR fly sightings from October 2017 until February 5–12, 2018, when 11 flies were sighted in the main OR rooms, and the center core where sterile supplies are stored. The Medical Center closed ORs 1–8 on February 5, reprocessed all the sterile instruments, and re-opened on February 7, after more than 24 hours without a fly sighting. On February 12, staff reported three more sightings, and ORs 1–8 were again closed. The separate ORs 9 and 10 remained open because no flies were sighted there. In the interstitial space, the Medical Center found debris, a pipe that was leaking water onto the floor, and a wet/dry vacuum cleaner full of debris. A rodent carcass covered in hatched larvae was also found outside of the building under a pipe from the interstitial space; it was removed and the area thoroughly inspected.

The Medical Center cancelled a total of 40 surgeries due to these two closures. Of these, the Medical Center rescheduled 36 (90 percent) to have their surgery done in less than 30 days after their cancellation. One patient declined to have their surgery rescheduled and Medical Center staff members have been unable to reach another patient to reschedule his surgery. We will review these cases to determine the amount of time that passed before their rescheduled surgery was completed, and if any patient experienced an adverse outcome as a result of the delay.

E. Current Actions

At this time, the Medical Center is addressing the situation by surveillance, monitoring, and intervention, including additional cleaning, resterilization of instruments, and continued vigilance with preventive measures. Although the Medical Center monitors the presence of flies on a daily basis during the week, we found no evidence of any formal tracking or trending (graphs, charts) of assessments or communication of this information. It is addressing fly entrance into the building with air curtains, vinyl strip

door curtains at the loading dock bay door, and is planning to replace all of the plumbing in the interstitial space this calendar year. EMS and OR staff are actively addressing any sightings of flies, and EMS staff is involved in preventative measures with the plumbing. The Medical Center continues to consult with VACO's pest management expert, as well as its contracted pest control company to ensure all steps are taken to remediate the fly issue.

F. Other

During our site visit, we noted that the Medical Center leaves the main entrance doors open at times allowing flies to freely enter the facility with little or no impediment. These doors open with motion sensors for approaching traffic, but at times the sensors are turned off and the doors left open.

Conclusions for Allegation 1

- We **substantiate** that from November 2016 through February 2017, the presence of flies in the OR caused the closure of multiple ORs and the cancellation of patient surgeries. The OR closures were appropriate to ensure patient safety.

- The Medical Center rescheduled and completed 71 percent of these surgeries within 30 days of being cancelled and 20 percent within 60 days of being cancelled.

- We found no evidence that during this period any patient suffered an adverse outcome due to the presence of flies or the delays caused by surgical cancellations.

- From November 2017 through February 2018, the presence of flies caused the closure of multiple ORs and the cancellation of 40 patient surgeries. The OR closures were appropriate to ensure patient safety. The Medical Center implemented actions in a timely manner to address each sighting and attempted to eliminate the presence of flies in the OR. These actions included extermination, placement of fly lights, consulting with VACO, and contracting an entomologist and pest controllers. However, at times, the Medical Center's main entrance doors are left open, allowing flies access to the building.

- The Medical Center is not tracking or trending the presence of flies, a practice which could provide valuable information, identifying factors that contribute to the presence of flies in the OR, or timing the flies' presence in the OR.

- Despite the Medical Center's contract with a pest control company, it has the overall responsibility for pest management.

Recommendations to the Medical Center

1. Determine whether any patient whose surgery was cancelled in February 2018 experienced any adverse outcomes due to the delay.

2. Continue to monitor for flies daily and immediately take action to eliminate them; ensure all departments involved in the elimination of flies from the OR are kept informed. Utilize tracking and trending information to assist with remediation efforts.
3. Ensure that the assigned staff members treat drains on a weekly basis and document each treatment.

4. Ensure facility inspections occur on a regularly scheduled basis in all areas of the Medical Center, taking a proactive approach to prevent the presence of flies whenever possible, and react appropriately.

5. Complete a standard operating procedure and educate staff regarding pest prevention and surveillance processes to ensure they understand actions in response to insect sightings.

6. Continue to consult with the VACO pest expert and external pest control sources as needed.

7. Determine whether there are gaps in the interstitial space between the 5th and 6th floors through which flies could access the OR; if found, consider sealing these breaches with a solid barrier such as drywall. Continue the surveillance process for flies in the OR.

8. Ensure the main entrance door sensors remain on and the doors are not left open at any time.

9. Consider air curtains to prevent flying insects from entering the building.

Allegation 2

Since 2016, sewage water leaks have caused the closure of multiple ORs and cancellation of patient surgeries.

Findings

A. Water Leaks in the OR, Case Cancellations and Rescheduling

Most patients with renal failure at the Medical Center are dialyzed in the hemodialysis unit on the 6th floor. Between the 6th and the 5th floor OR area, lies an interstitial space housing the electrical, plumbing, and air handling equipment that includes the ventilation, electrical, and plumbing from the dialysis unit, and previously a dialysis waste storage tank. The pipes that carry dialysis effluent are 20–30 years old, made of cast iron, and corroded by the acidic dialysis waste causing them to leak. In the past, a storage tank was used to store and neutralize the liquid waste from the dialysis process, but it is no longer used and was removed in April 2017. Since 2016, the iron pipes have leaked into the OR on eight occasions, two of which resulted in significant damage.

One leak resulted in the closure of 8 of the 10 ORs for 14 days, and another caused the closure of OR 4 for 10 days. On six occasions in March 2016, OR staff noted a leak in the area where sterile supplies and instruments are stored. They closed ORs 1–8, cancelling and rescheduling 26 cases. Of these, the Medical Center rescheduled and completed:

- 21 within 30 days of being cancelled; 1 patient's rescheduled surgery was aborted due to a change in his condition. This change was unrelated to the condition for which he was having surgery. He was sent for additional diagnostic testing and referred back to have his surgery rescheduled. The patient was not available for follow up until 4 months later;

- 3 within 60 days of being cancelled;

- 1 patient ate on the morning of his rescheduled back surgery, which had to be cancelled. Shortly after, he was diagnosed with colon cancer and underwent treatment. Following his cancer treatment, he underwent back surgery 1 year later;

- 1 patient declined to have his surgery rescheduled (the patient believed his condition no longer warranted surgery).

We reviewed the Medical Center's quality data and the EHRs of those patients whose surgery was delayed because of the water leaks in the OR and found no evidence that any of them experienced an adverse outcome as a result of the cancellations.

B. Current Actions

Air handling units above the OR were refurbished and waterproofed in October 2016, improperly fitted dialysis machine drain hoses were corrected, and the aging piping system in the interstitial space repaired. Two leaks in November 2016, resulted in the closure of one OR for 10 days; the other affected OR was inspected and Engineering staff determined the room was safe for use and would not need to be closed for repair of the leak. No cases were cancelled. The Medical Center determined that these were roof leaks and repaired the roof and cracked storm drain pipes in March 2017. In May 2017, the Medical Center began planning for the replacement of the plumbing for the dialysis unit and interstitial area to occur in calendar year 2018

On November 25, 2016, a drop of water came from the ceiling of OR 1 and was traced to the humidification system located above the ceiling of the ORs; the Medical Center addressed the issue.

Conclusions for Allegation 2

- We **substantiate** that since 2016, water leaks have caused the closure of multiple ORs and cancellation of patient surgeries. The OR closures were appropriate to ensure patient and staff safety while leaks were repaired.

- We found no evidence that any of the patients whose surgery was cancelled because of leaks in the OR, experienced adverse outcomes as a result of these delays.

- The Medical Center repaired leaks and is preparing to proactively replace all of the pipes in the interstitial space.

Recommendations to the Medical Center

10. Continue to monitor for leaks and repair any identified as soon as possible.

11. Continue to take the appropriate measures to ensure patient and staff safety when leaks are discovered and while leaks are repaired.

12. Continue with plans to replace the piping.

Allegation 3

From June 2017 to present, ORs have been critically short on surgical supplies; gloves, hand towels, peroxide, gauze, sterile gowns, syringes, 4x4 sponges.

Findings

The whistleblower explained that since June 2017, the ORs have persistently been critically short of, or out of stock of, surgical supplies including sterile gloves and gowns, syringes, 4 x 4 sponges, peroxide, gauze, and hand towels for draping patients and drying surgeons' hands. At times he has had to delay surgeries 20 to 30 minutes in order to locate needed supplies.

It is VHA policy to standardize to the maximum extent possible the types and kinds of supplies and equipment it purchases, consistent with clinical and practitioner needs. VHA purchases its supplies from a prime vendor in order to standardize them and facilitate best-value product pricing through volume purchasing. The Medical Center sets a required minimal level that should be on site at all times, or Periodic Automatic Replenishment (PAR) level, based on previous use. Once received, the Medical Center's Logistics Service staff inputs the supply items and amounts received into an electronic tracking system, then distributes to the points of care. Once the amount on hand falls below the PAR level, the Medical Center's electronic system automatically reorders the supply.

In early 2017, VA changed its prime vendor. In preparation for this change, the expectation was for the local Logistics Service to order additional supplies, in order to

ensure an adequate supply during the transition. However, the Medical Center discovered that the previous Logistics Service leadership ordered some supplies without entering the items in the electronic system, so the items were not visible, but were physically present in the facility. In many instances, some supplies, such as gauze and surgical gloves, were not restocked in the OR supply area, resulting in delays in starting surgery. At times, OR staff members were able to obtain the supplies from a different area or from a different surgical supply pack. When they contacted the central supply area, the items were found and provided. The Medical Center has replaced the Logistics Service leadership. Since August 2017, staff indicated that there have been very few, if any, occurrences of unavailable surgical supplies. We reviewed all OR patient safety events for FYs 2016 and 2017, and found no evidence of case cancellations because adequate supplies were unavailable.

Conclusions for Allegation 3

- We **substantiate** that the OR has been short on surgical supplies; however, since August 2017, there have been very few, if any, instances when supplies were not readily available for cases.

- The previous Logistics Service leadership team did not ensure that all supplies were entered in the electronic system for tracking and automatic reorder.

Recommendation to the Medical Center

13. Ensure that the Logistics Service continues to properly track and automatically order supplies as needed.

Allegation 4

Understaffing, particularly of anesthesiologists and OR nursing staff, has affected the facility's ability to perform emergency surgery during the evenings and on weekends and has caused OR closures (Bumped days).

Background

Anesthesiologists and CRNAs are anesthesia providers directly involved in a patient's care before, during, and after surgery. CRNAs are advanced practice registered nurses (APRN) who administer anesthesia and other medications. They also monitor patients who are receiving anesthetic agents and recovering from anesthesia. Anesthesiologists are physicians who specialize in the field of anesthesiology. They manage medical problems if they occur during surgery, oversee patient care in the Recovery Room after surgery is completed, and determine when the patient is ready to leave the Recovery Room. Anesthesiologists also supervise CRNAs if the latter's state license requires this. Anesthesiologists are also responsible for providing oversight to anesthesiologists in training (residents) and back up for CRNAs.

Findings

A. Medical Center OR Staff

In order to ensure patients receive safe and timely care, the OR must maintain an adequate number of anesthesia providers, who cover all scheduled cases, and urgent and emergent cases during regular duty hours and weekends, holidays, evenings and night (WHEN) tours of duty. At the Medical Center, one anesthesiologist is assigned to cover 2–3 CRNAs, in case the patient requires additional anesthesia expertise. Currently, the anesthesia section staffs 10 fully-functional ORs (8 of which the Medical Center uses on a daily basis) and 2 non-OR locations, Pain Clinic and consultation areas. Normal operating hours are 8:00 a.m. through 3:00 p.m., after which four ORs continue to operate from 3:00 p.m. through 7:00 p.m. Surgeries that extend past 7:00 p.m. are covered by the on-call team of anesthesia providers and nurses. The Medical Center has two on-call teams of nurse and anesthesia providers: one team for cardiac surgery and one for all other surgeries. The on-call team is called in for emergency cases during the WHEN hours, and, per our review of the surgical data, there have been no delays in emergency cases due to the consistent availability of these two on-call teams.

Although the Medical Center has 10 fully-functional ORs, they use 8 on a consistent basis. ORs 9 and 10 are fully functional but smaller in size and used less frequently. These two ORs were used when the main ORs were closed and thus lessened the impact on wait time for patients that needed to be rescheduled for surgery. The wait time for some services, such as neurosurgery, can be 60–90 days for elective cases, and these patients, if eligible, are offered the option to receive care through the Choice/Community Care program if Neurosurgery cannot see them within 30 days. If Neurosurgery is fully staffed, the use of ORs 9 and 10 could decrease the wait time for this service and the number of patients sent out for Community Care. However, in order to support more frequent use of these rooms, the Medical Center must ensure there is sufficient anesthesia and nursing staffing.

B. Anesthesia Staffing

The Medical Center is allotted 15.825 full-time equivalents (FTE) for anesthesiologists, and, as of January 2018, there are 5.825 (approximately 34 percent) anesthesiologist vacancies. The CRNA FTE ceiling is 16.75; the Medical Center transferred 2 FTEs to the Emergency Department (ED), in exchange for the ED providers taking responsibility for emergency airway management outside of the OR. Two CRNAs are on extended leave, and two are planning to leave as soon as possible. The Medical Center currently has 6.75 (approximately 45 percent) FTE CRNA vacancies. When staff members use leave, planned or unplanned, these vacancies can have an even greater impact on the Medical Center's ability to provide surgical care. In comparison, a VA medical center with a similar anesthesia workload has 16 anesthesiologists and 14 CRNAs.

Some factors that contributed to Anesthesia staff shortages are lack of support from HR; the HR staff members were not aware of their ability to utilize their direct hire authority for hiring CRNAs. We saw no positions posted for anesthesia providers in USAjobs.com, the Federal Government employment posting site. As expressed by representatives from many other services, there is very little or inadequate support from the HR department; examples cited by hiring officials included HR's failure to post or delay posting, job announcements, failure to complete the pre-employment process in a timely manner, and failure to follow up with candidates, leading to the loss of potential employees. The Medical Center is experiencing significant HR challenges, including understaffing and inadequate training of its HR staff. In an effort to improve efficiency and effectiveness, the Medical Center has hired a new chief for HR and is providing additional training for the current staff, as well as working directly with VACO's workforce management staff to perform many of the HR functions for the facility until the existing staff are retrained, re-assigned as needed, and additional members are hired. Also, the Anesthesia Service does not have a dedicated Administrative Officer, who would be able to consistently follow up on HR issues, as well as other administrative functions for the Service.

Another contributing factor to the Anesthesia staff shortages is the salary that appears insufficient for effective recruitment and retention of highly qualified providers. The starting salary for an anesthesiologist at the Medical Center is $285,000 with a maximum of $400,000. We were told that recruits are often offered the lower end of the salary scale, even though they could be offered a significantly higher amount, and the salary range at the Medical Center is significantly lower than that at nearby non-VA facilities. Many Medical Center anesthesiologists supplement their income by working part-time at the academic affiliate, UCLA, in order to be able to maintain what is considered to be an acceptable standard of living in the greater Los Angeles area.

In terms of productivity per FTE, the Medical Center has 13,577 relative value units (RVU), 119 percent of the targeted level, indicating a high workload, which may justify hiring additional Anesthesia staff.[1]

C. OR Nurse Staffing

The role of the perioperative/OR nurse is to provide care for patients before, during, and after surgery. Nurses in the OR assist the surgical team by preparing the room, providing direct patient care, handing instruments to the surgeon during the procedure, and ensuring all needed supplies and equipment are available during the procedure. We found that the nurses coming in on day shift set up the ORs because there are not enough OR nurses and surgical technicians on the evening shift to prepare the rooms for cases scheduled the following day. This practice could have a negative impact on the efficient use of OR resources, and could reduce the number of cases the OR staff members are able to complete. As of December 2017, the Medical Center's OR has

[1] RVU is used by Medicare to determine the fee for services depending on the resources needed to provide a service; these resources include the physician's time, technical skill and effort, and mental effort, among other things. (https://www.nhpf.org/library/the-basics/Basics_RVUs_01-12-15.pdf). Updated January 2015.

four RN and three surgical technician vacancies, which they cover with overtime usage, as evidenced by an increase in the use of OR overtime dollars during FY 2017. We reviewed the facility's OR staffing methodology and determined that the OR's nursing FTE is consistent with the staffing methodology guidelines set forth by the Association of Perioperative Registered Nurses, the professional organization for OR nursing.

D. Bumped Days

On a weekly basis, each surgical service is allotted a certain block of time to operate. Because of Anesthesia staff shortages and the environmental issues noted in the first two allegations, Surgical Service leadership, at times, changes the blocked time for surgeries, in an attempt to ensure each service has the opportunity to get as many of their previously cancelled cases done and that there is an equitable distribution of available OR time. The loss of a service's scheduled OR block time is referred to as a "Bumped Day." The Surgical Service makes these changes 30 days or more in advance. During FYs 2016–2017, of the 1,272 cases cancelled, the Medical Center cancelled 90 (7 percent) because of staffing issues. Scheduled non-emergent surgeries are also cancelled and rescheduled for a different time or day if an emergency surgery needs to be done. We found no evidence that the Medical Center did not perform or delayed emergency surgeries because of a lack of anesthesia or nursing staff during normal business hours, as well as WHEN hours. This appears to be due to the availability of the two on-call surgical teams and staff members' willingness to work additional shifts for overtime pay.

Conclusions for Allegation 4

- We **do not substantiate** that understaffing, particularly of anesthesiologists and OR nurses, has affected the facility's ability to perform emergency surgery during normal business and WHEN hours. The Medical Center is staffed with two on-call surgical teams who have enabled emergency surgery to continue to occur when needed.

- We **substantiate** that staffing issues have contributed to scheduling and block time changes.

- Based on the volume and complexity of surgical cases performed at the Medical Center and productivity per FTE, the Medical Center should fill all Anesthesia provider vacancies, and determine whether the Anesthesia Service needs additional staff.

- Consider the feasibility of using ORs 9 and 10 more frequently in an effort to decrease wait times. This determination should be based on resource needs, including staff, equipment, and supplies.

- Because of staff shortages on evening shifts, the day shift nurses are setting up ORs when they arrive for their tour of duty; this could have a negative impact on the

efficient use of OR resources, and could reduce the number of cases the OR staff is able to complete.

- The HR Service's inadequate staffing and inefficient processes has negatively impacted the Medical Center's ability to hire staff for the Anesthesia and other services in a timely manner. The Medical Center is in the process of taking steps to address this concern including working with the VACO Workforce Management team.

- The Anesthesia Service does not have a dedicated Administrative Officer, who would be able to consistently follow up on HR issues, as well as other administrative functions for the Service.

Recommendations to the Medical Center

14. Aggressively recruit for and fill all Anesthesia and Nursing Services' vacancies as soon as possible.

15. Ensure vacancies are posted on USAjobs.com and hiring actions are taken in a timely manner.

16. Utilize available strategies to retain current staff including the Education Debt Reduction Program, recruitment and retention, salary waivers, and other options to improve attractiveness of VA positions.

17. Aggressively recruit for additional HR staff.

18. Provide additional training for current HR staff members, including use of direct hire authorization, use of continuous open listing, and other HR options to increase efficiency of the HR hiring process. Continue the plan to utilize agreement with the VACO Workforce Management team. Once the training has been provided to all HR staff, assess effectiveness, monitor for compliance, and address noncompliance as indicated.

19. Consider assigning a dedicated Administrative Officer or support staff member to the Anesthesia Service to ensure all issues are addressed, including those of HR.

20. Notify VISN 22 of any critical staffing shortages.

Allegation 5

The lack of an interventional neuroradiologist and neuropathologist has affected the facility's ability to diagnose and remove spinal and brain tumors.

Background

The central nervous system is made up of the brain and the spinal cord. Neurosurgery is a branch of surgery that treats conditions and diseases of the brain and nervous system. Radiology is a medical specialty that helps diagnose and treat conditions and diseases using various radiologic image capturing techniques and interpretation. Interventional neuroradiology is a subspecialty within radiology and involves introducing catheters and using radiology imaging to diagnose and treat neurological conditions and diseases.

Findings

A. The Medical Center's Neuroradiology Services

Until 2014, the Medical Center employed a neurovascular surgeon who was also trained as an interventional neuroradiologist and performed these procedures; since that time the Medical Center has attempted bring on another provider, but was not successful. The former Chief of Radiology and current acting Chief of Radiology reportedly contacted HR for follow up, but have received no feedback about the status of posting and filling this position. The current acting Chief of Radiology is writing another proposal for an interventional radiologist for a full-time position, sharing with UCLA, or contracting with fee-basis. At the present time, the Medical Center does not have a contract with another facility to provide this service. The facility cannot offer patients with non-acute neurovascular disease elective diagnostic testing (e.g., cerebral angiography) or treatment, but instead utilizes programs such as Choice to send eligible patients to other facilities with these capabilities; patients not eligible for Choice are sent to UCLA (which is not a Choice provider) if a bed is available. The neurosurgeons reported that the referral and scheduling process often resulted in delays in obtaining the elective diagnostic and interventional procedures. The Medical Center reported that at least one patient received an incorrect diagnostic procedure at the community facility and had to return to VA to have the correct procedure. The patient did not suffer harm related to the delay in diagnosis and treatment planning, according to both of the neurosurgeons at the Medical Center and the neurosurgeon who was part of our investigative team. The neurosurgeons also claim that patients grow frustrated with the slow and burdensome referral process to other facilities, to the point where some patients give up and never receive their elective neurovascular diagnostic or therapeutic interventions. The neurosurgeons were unable to provide specific examples of a patient harmed by failing to undergo the non-acute, non-emergent neurovascular diagnostic or therapeutic intervention, but they are concerned that these failures may result in patient harm in the future.

B. Adverse Outcomes

We reviewed the neurosurgical cases completed and found no evidence of any adverse events related to a lack of neuroradiology interventional services. However, when the facility employed a neurosurgeon with interventional neuroradiology training, it was able

to offer patients the full range of diagnostic and therapeutic neurovascular interventions for acute and non-acute neurovascular conditions. Since the loss of the neurovascular surgeon, the facility has a reduced capability to treat the spectrum of patients with neurovascular disease, e.g., brain hemorrhage, or to accept patients from other facilities and must transfer patients who may need such specialized services from the ED to another facility. Although we did not find delays that led to adverse patient outcomes, the lack of a contract or other formalized arrangement with other facilities for treatment of patients with acute neurovascular disease could lead to a significant delay.

C. The Medical Center's Neuropathology Services

Neuropathology is the study of diseases of the nervous system, and typically includes the laboratory analysis of tissue samples for diagnosis. Neuropathologists provide cellular and molecular diagnoses and conduct research in this field; common areas of study are brain tumors, Alzheimer's disease, stroke, muscular dystrophies, infections, and brain development. Prior to 2015, the Medical Center employed a surgical pathologist with expertise in neuropathology; this person's pathology responsibilities were not exclusively neuropathologic, but he provided pathology readings for other services as well. After this provider departed, the Medical Center attempted to contract with UCLA for neuropathologic services, but this process has not reached completion.

During neurosurgical procedures to remove certain tumors, the pathology specimens are analyzed microscopically by the neuropathologist to assist the surgeon in determining whether the entire tumor has been resected. The neurosurgeons, including the whistleblower, stated that, to date, there were no cases where the treatment plan would have differed if a neuropathologist had been available at the Medical Center. However, the neurosurgeons interviewed did envision scenarios during certain tumor surgeries where a neuropathologist's expertise in reading a frozen section might prompt them to make a more informed decision about whether or not to perform additional surgical resection.

D. Adverse Outcomes

In our review of neurosurgery cases completed, we found no evidence of adverse events due to the lack of a neuropathologist.

Conclusions for Allegation 5

- We **do not substantiate** that the lack of an interventional neuroradiologist and neuropathologist has affected the facility's ability to diagnose and remove spinal and brain tumors.

- Although we found no evidence of any adverse events related to a lack of interventional neuroradiology services, the lack of a contract arrangement with other facilities for treatment of patients with acute neurovascular disease could lead to significant delays.

- The services of a readily available neuropathologist could help the surgeons make more informed decisions during the removal of certain types of tumors.

Recommendation to the Medical Center

21. Develop recruitment or sharing agreements with an affiliate or nearby facility to acquire neuroradiology and neuropathology services, given that the Medical Center is classified as capable of providing care for the most complex patient scenarios.

VI. Summary Statement

OMI has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, the Office of General Counsel has provided a legal review, VHA HR has examined personnel issues to establish accountability, the Office of Accountability and Whistleblower Protection (OAWP) has reviewed the report to determine whether it makes findings against senior leaders requiring OAWP action, and the National Center for Ethics in Health Care has provided a health care ethics review. We found past violations of VA and VHA policy on the part of the Logistics Service, and note that a substantial and specific danger to public health and safety exists at the Medical Center due to water leaks and flies.