



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 13-03747-76

Healthcare Inspection

Environment of Care Deficiencies in the Operating Room VA Connecticut Healthcare System West Haven, Connecticut

February 18, 2014

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:

Telephone: 1-800-488-8244

E-Mail: vaoighotline@va.gov

Web site: www.va.gov/oig

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to allegations about deficiencies in the environment of care in the operating room (OR) at the VA Connecticut Healthcare System (facility), West Haven, CT. It was alleged that:

- Terminal cleaning procedures in the OR are not performed appropriately.
- Environmental Management Services (EMS) has insufficient staff resources assigned to the OR.
- EMS staff do not utilize standard operating procedures (SOPs) or checklists for cleaning that are consistent with recognized industry standards.
- Patients with infectious diseases who may require special precautions are scheduled for surgical procedures throughout the day along with patients who are not infectious.
- OR staff are not always made aware of an infectious patient's precaution status prior to the arrival of the patient.

We substantiated all five allegations. We found that cleanliness of the OR could not be assured due to inadequate staff resources, incomplete and inconsistent SOPs, poor supervision and training of EMS staff, and lack of oversight. We also found that safeguards were inadequate for ensuring patient and employee safety when infectious patients requiring special precautions were scheduled for OR procedures concurrently with noninfectious patients. In addition to the original allegations, during the course of our review we identified issues related to maintenance of the Heating, Ventilation, and Air Conditioning (HVAC) system and insect control in the OR. Although our findings substantiated an increased risk to patients and staff, we found no conclusive evidence that the environment of care deficiencies in the OR resulted in negative patient outcomes.

We recommended that the Facility Director strengthen SOPs for OR cleaning and develop and implement policies and procedures to address management of infectious patients, HVAC preventive maintenance, and insect control in the OR. We also recommended that the Facility Director reassess EMS staffing needs in the OR, assign personnel requisite to the workload, and ensure that EMS staff and supervisors receive training on OR environment of care requirements. Additionally, we recommended that the Facility Director implement procedures to monitor the OR environment of care and to address identified deficiencies.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 9-13 for the Directors' comments.) We will follow up on the planned actions until they are completed.



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

Purpose

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection in response to allegations about deficiencies in the environment of care in the operating room (OR) at the VA Connecticut Healthcare System (facility), West Haven, CT. The purpose of the inspection was to determine the merits of the allegations.

Background

Facility Profile. The facility consists of two campuses, one located in West Haven and the other in Newington. The West Haven campus is a 230-bed tertiary care facility with patient care services that include internal medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, and geriatrics and extended care. Newington is an ambulatory care center that provides primary and specialty care.

The peri-operative area of the facility includes the OR suite¹ comprising 7 operating rooms with adjacent sterilizer and storage rooms, a pre-operative holding area, and the post-anesthesia care unit (PACU).² During the first 3 quarters of FY 2013, 2,120 surgical procedures were performed at the facility.

General housekeeping services within the OR are the responsibility of the facility's Environmental Management Service (EMS). The Chief of EMS reports to the Chief of Facilities Management Service (FMS) and is responsible for managing EMS supervisors who are assigned to various areas of the facility, including the OR. The typical EMS staff assignment for the OR is four EMS staff on the day shift and three on the evening shift.

Allegations. Prior to an OIG scheduled Combined Assessment Program (CAP) review³ of the facility in June 2013, the OIG invited facility staff to participate in an online Employee Assessment Review (EAR) survey. The EAR is an anonymous survey that offers all staff the opportunity to express their opinions about safety and the quality of care provided at the facility. The results from the facility included a number of reports of unsatisfactory conditions related to environmental management and infection control in the OR at the West Haven campus. Specifically, the survey results included the following allegations:

- Terminal cleaning of the OR after the day's procedures is not performed appropriately.⁴
- EMS has insufficient staff resources assigned to the OR.

¹ The OR suite is commonly referred to as the OR, which is the term we use in this report.

² The PACU is a part of the peri-operative suite where surgical patients are monitored during recovery from anesthesia.

³ The CAP review process is the periodic inspection of VA health care facilities by the OIG to evaluate selected facility operations, focusing on patient care quality and the environment of care.

⁴ Terminal cleaning is a process to deep clean and disinfect the entire OR procedure room and adjacent scrub/utility areas after the day's procedures. It includes wet vacuuming the entire floor and cleaning all horizontal surfaces, furnishings, and equipment, whether portable, fixed, or wall-mounted.

- EMS staff do not utilize standard operating procedures (SOPs) or checklists for cleaning that are consistent with recognized industry standards.
- Patients with infectious diseases who may require special precautions^{5,6} are scheduled for surgical procedures throughout the day along with patients who are not infectious.
- OR staff are not always made aware of an infectious patient's precaution status prior to the arrival of the patient.

Scope and Methodology

During the June 2013 CAP review, we conducted a preliminary review of the allegations, which included an unannounced visit to the OR. We returned to the facility August 12–14, 2013, to conduct an in-depth review specific to the allegations. We interviewed FMS and EMS chiefs, supervisors, and staff; OR physicians and nursing personnel; and other clinical, supervisory, and administrative staff. We also interviewed the Chief of Surgery and Chief of Anesthesiology, the OR Nurse Manager, and the facility epidemiologist. We reviewed relevant facility policies and procedures, training documentation, engineering reports, minutes of the OR Management Committee and Infection Control Committee, incident reports, and VA Surgical Quality Improvement Program reports and clinical outcomes data. We also reviewed applicable industry standards including The Joint Commission (JC) and Association of Perioperative Registered Nurses (AORN). We inspected the OR, the pre-operative holding area, and the PACU.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

⁵ In this report, we are interpreting special precautions to denote transmission-based precautions which include three categories reflecting the major modes of microorganism transmission in hospital settings: contact, droplet, and airborne spread. Precautions may include isolating the patient from contact with others and the use of personal protective equipment and are required for patients known or suspected to be infected, or colonized, with select infectious microorganisms.

⁶ Siegel JD, Rhinehart E, Jackson M, Chiarello L, the Healthcare Infection Control Practices Advisory Committee, *2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*. <http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html>. Accessed on December 20, 2013.

Inspection Results

We substantiated all five allegations. We found that cleanliness of the OR could not be assured due to inadequate staff resources, incomplete and inconsistent SOPs, poor supervision and training of EMS staff, and lack of oversight. We also found that safeguards were inadequate for ensuring patient and employee safety when infectious patients requiring special isolation precautions were scheduled for OR procedures concurrently with noninfectious patients. During the course of our review, we identified other issues, not identified in the EAR survey, related to maintenance of the Heating, Ventilation, and Air Conditioning (HVAC) system and the intrusion of insects in the OR.

Issue 1: OR Environment of Care

We substantiated that terminal cleaning of the OR is not performed appropriately and that a shortage of trained EMS staff assigned to the OR and an incomplete SOP and checklist inconsistent with recognized industry standards were contributing factors.

Guidelines for environmental cleaning in the OR have been developed by AORN and are widely recognized as the industry standard.^{7,8} The facility's OR infection control policy, which references AORN, requires that EMS staff receive "special training on room cleaning between cases" to include cleaning floors, furniture, and light fixtures.⁹ The policy also requires EMS staff to perform terminal cleaning of the OR at the end of the day using hospital-approved detergents and disinfectants. In addition, an EMS SOP outlines requirements for properly cleaning the OR and lists general equipment and supplies to be used and procedures to be followed.¹⁰ The SOP includes a terminal cleaning checklist that must be completed and signed by EMS staff and verified by EMS supervisors. The facility's OR Management Committee is responsible for monitoring patient safety and cleanliness in the OR.¹¹

During our inspection, OR and PACU staff reported that when they arrived for the first cases of the day, they often found indications that rooms had not been terminally cleaned the previous evening. For example, they would find debris and dust on the floor under furniture and equipment, indicating that the furniture and equipment had not been moved to accommodate terminal cleaning. Smaller equipment items, such as oxygen tanks and electrical cords or tubing, would be on the floor from the final

⁷ Conner R, et.al., Ed., Perioperative Standards and Recommended Practices, Association of periOperative Registered Nurses, Vol. 1, 2013. Accessed on September 5, 2013.

⁸ AORN recommended standards are evidence-based, authored by AORN nursing specialists, and developed in collaboration with liaisons from the American College of Surgeons, Association for Professionals in Infection Control and Epidemiology, the Centers for Disease Control and Prevention, and other nationally recognized organizations.

⁹ VA Connecticut Healthcare System, *Infection Control Department Policy, Operating Room*, June 2013 (and prior version dated March 2007).

¹⁰ VA Connecticut Healthcare System, *EMS SOP 35, Operating Room Cleaning*, March 20, 2012.

¹¹ VA Connecticut Healthcare System Policy 00-166, *Operating Room (OR) Management Committee*, June 28, 2007.

procedure of the previous day. Also, trash was not emptied, and restrooms were not clean.

Several OR and infection control staff expressed opinions that the facility lacked procedures to differentiate terminal cleaning from between-case cleaning.¹² Furthermore, OR Management Committee minutes repeatedly addressed concerns that terminal cleaning is “not being done” and a need to either “get caught up” or contract with an outside vendor and cited the need to “establish a schedule for terminal cleaning.” The minutes also reported incidents of EMS staff eating in the pre-operative holding room in violation of facility policy.¹³

Based on our interviews with facility staff and managers, observations onsite, and review of pertinent documents, we identified five factors—including two factors identified in the original allegations—contributing to cleanliness issues in the OR.

Shortage of Staff. Terminal cleaning for most ORs is performed during the evening shift. The FMS and EMS chiefs acknowledged that an evening shift EMS position has been vacant since January 2013. As a result, only two, instead of the usual three, EMS staff are assigned to this shift. The FMS and EMS chiefs reported that EMS staffing problems are facility-wide, making it difficult to backfill in the OR. Furthermore, because of special training requirements for EMS staff in the OR, reassigning staff from other areas in the facility is difficult. At the time of our inspection, EMS had an authorized staffing level of 125 and 38 position vacancies. Furthermore, facility managers determined that on an average workday, 19 percent of the EMS staff did not report to work.

The FMS and EMS chiefs expressed concern that human resources has not been responsive in filling vacancies for EMS positions. The Human Resources Manager confirmed that delays within his department were a contributing factor and that they recently had been resolved.

Incomplete SOPs Inconsistent with Industry Standards. Although the facility has an established SOP and checklist for cleaning in the OR, we found that these documents lack sufficient detail and do not reflect key elements of industry standards. For example, the SOP does not distinguish between terminal cleaning and in-between-case cleaning, and the checklist is only for terminal cleaning. The SOP also does not establish that terminal cleaning must take place every 24 hours during the work week, to include rooms that were not used. It does not include a schedule or process for cleaning of storerooms, hallways, patient waiting areas, or other ancillary areas. Furthermore, the SOP does not address procedures for cleaning an OR that has been used for an infectious patient. For waste handling and soiled linen, the SOP refers to

¹² Between-case cleaning is performed during room turnover between patients to address equipment used during the case plus the furnishings and floor immediately surrounding the focus area or patient area. It is less intensive than the terminal cleaning performed at the end of the day following completion of the surgical schedule.

¹³ VA Connecticut Healthcare System, *Infection Control Department Policy, Facilities Management Service*, August 2010; VA Connecticut Healthcare System, *Infection Control Department Policy, Operating Room*, June 2013.

two other SOPs and an unnamed policy. Furthermore, the SOP (as well as the facility's OR infection control policy) is missing other key provisions of the AORN guidelines, such as specific training requirements for EMS staff working in the OR and a formal quality management program to evaluate processes and outcomes of the environmental cleaning and disinfection in the OR.

Inadequate Supervision. We identified several concerns regarding EMS staff supervision. During an unannounced evening inspection of the OR, we saw no EMS staff for almost an hour, when two staff members should have been present. EMS supervisors we spoke to could not explain the absence of employees during this time. We found that terminal cleaning checklists completed by EMS staff were not verified and signed by EMS supervisors. In addition, several OR nurses we interviewed stated that they rarely saw EMS supervisors in the OR.

The FMS and EMS chiefs acknowledged supervision problems and stated that they were "not surprised" that OR nursing staff reported that they rarely saw EMS supervisors in the OR. The Human Resources Manager cited the frequent turnover of the Chief of EMS position as a reason for inadequate supervision.

Inadequate Training. During our interviews with EMS supervisors, we found that some were unclear regarding the frequency of OR cleaning procedures and could not provide specifics as to how they trained and evaluated their subordinates. One EMS supervisor assigned to the OR indicated that he was not formally trained for the assignment, and he sought his training from subordinates and OR nursing staff. The Chief of EMS confirmed that another supervisor had been transferred from a position in a different building and that the supervisor had not yet received formal training to oversee specialty areas such as the OR. The Chief of EMS also cited difficulty in tasking supervisors with some training responsibilities since they involved skills not listed in the supervisors' job descriptions.

We reviewed EMS training records and found that many lacked dates of training, length of training, and/or details regarding training content. Some training records, specific to OR cleaning, listed as a facilitator a supervisor who was not formally trained in OR cleaning.

No Evidence of Oversight. Although the facility's OR Management Committee is responsible for monitoring cleanliness and safety in the OR, and committee minutes consistently noted environment of care deficiencies, we found no documentation that definitive actions had been taken to address problems over a 10-month period (since October 2012).

Issue 2: Safeguards for Scheduling Patients Requiring Isolation Precautions

We substantiated that infectious patients who may require special precautions are scheduled for surgical procedures concurrently with noninfectious patients and that staff were not always made aware of a patient's precaution status prior to the arrival of the patient.

The practice of concurrent scheduling of infectious patients who may require special precautions with noninfectious patients is not prohibited by Veterans Health Administration or facility policy as long as adequate safeguards are in place to reduce the risk of exposure. Previous facility policy specified that staff receiving a patient requiring transmission-based precautions have advance notification of that patient's status and type of precautions required.¹⁴ To improve management of patients requiring precautions in the peri-operative setting, facility managers updated this policy subsequent to our CAP site visit in June 2013.¹⁵ Another policy revision addressing patients requiring precautions in the PACU was still in draft form at the time of our return visit in August 2013.¹⁶

Scheduling of Patients Requiring Isolation Precautions. The OR Nurse Manager, the Chief of Surgery, and the Assistant Chief of Surgery all confirmed that both infectious patients who may require precautions and noninfectious patients are concurrently scheduled for surgical procedures throughout the day. OR leadership indicated that patients with droplet, wound, or respiratory infections do not go to the pre-operative holding area or the PACU. The patients go from their ward directly into OR procedure rooms and back to their rooms on the wards following procedures. If more intensive post-operative recovery is warranted, patients go to isolation rooms in the surgical intensive care unit. Patients requiring respiratory precautions are scheduled at the end of the day.

OR and infection control staff also described actions taken to reduce the risk of disease transmission by patients on standard contact precautions. In the pre-operative holding area and PACU, these patients are placed in an end stretcher next to a wall and are separated from the next patient by an empty stretcher bay. A supply cart with personal protective equipment is placed in front of the curtains enclosing the stretcher bay with signage indicating that contact precautions are required. Terminal cleaning is performed after the patient leaves and, to enhance this process, disposable paper curtains surrounding the stretcher bay are discarded. At the time of the CAP site visit the disposable curtains were unusable because of missing hardware to hang the curtains; however, this situation has been resolved.

Notification for Patients Requiring Isolation Precautions. Staff indicated they were often unaware of a patient's precaution status prior to the patient's arrival in the OR, and on occasion they were not made aware of the patient's status until after the procedure was completed and the patient was in the PACU. The delay was attributed to the fact that a majority of surgeries are outpatient, and pre-assessments to determine the need for precautions are not done until the day of surgery. According to facility leaders, they have changed the process so that a patient's precaution status is evaluated during the anesthesia pre-screening appointment 2 weeks before surgery. On the day of surgery, any laboratory procedures still required to determine the patient's precaution status are prioritized, and results are immediately telephoned to the OR.

¹⁴ VA Connecticut Healthcare System, *Infection Control Department Policy, Operating Room*, March 2007.

¹⁵ VA Connecticut Healthcare System, *Infection Control Department Policy, Operating Room*, June 2013.

¹⁶ VA Connecticut Healthcare System, *Infection Control Department Policy, PACU*, DRAFT, July 2013.

All staff interviewed acknowledged that improvements in communicating precaution status were made in the interval between the CAP and hotline site visits. The information “handoff” system was enhanced, and the written communication accompanying patients now includes placement of a precaution notice that is visible when the patient is transported. Signage indicating the need for precautions is also posted in each area of the peri-operative suite as the patient location changes.

Issue 3. Other Environment of Care Concerns

In addition to the allegations in the EAR survey, our inspection revealed other environment of care issues that have a potential impact on patient safety and quality of care.

AORN recommends that patients should have a clean and safe environment and stipulates that “ventilation ducts should be cleaned and filters changed on a regularly scheduled basis.”¹⁷ Although AORN does not reference a specific timeframe, it does recommend an established schedule. Further, AORN recommends that “measures should be taken to prevent vermin infestation of the perioperative environment.”¹⁸

HVAC Maintenance. The Chief of Surgery expressed serious concerns regarding maintenance of the facility’s HVAC system and how it might impact patient safety in the OR. These concerns are also reflected in the minutes of the OR Management Committee, which document ongoing issues or questions regarding cleaning of the HVAC ducts, loss of positive pressure in some ORs, and excessively high humidity. Facility maintenance reports show a number of deficiencies that were discovered and corrected by an HVAC contractor. “Substantial errors” were noted in calibration of pressure monitors; monitor alarms had been permanently muted; and pressure lines were found reversed, causing two ORs to be operating at negative instead of positive pressure.

Despite these concerns, we found that the facility lacks a formal, comprehensive policy that addresses preventive maintenance and cleaning of the HVAC system in the OR. Engineering officials provided us with samples of a form listing preventive maintenance “check points.” The form includes check-off boxes that provide the user with choices that range from weekly to yearly but no guidance as to what specific maintenance is required and how often it is required. Engineering officials also provided us with a computer-generated report that lists dates and times of HVAC inspections, which appear to be performed on a quarterly basis. However, none of the documentation provided details on issues that were discovered or how they were tracked or resolved.

Insect Control. OR staff we interviewed indicated that flying and crawling insects have been an ongoing problem in the OR for about 8 years. Occasional insect intrusion was also documented in incident reports we reviewed and was confirmed by the chiefs of

¹⁷ Conner R, et.al., Ed., *Perioperative Standards and Recommended Practices*, Association of periOperative Registered Nurses, Vol. 1, 2013. Accessed on September 5, 2013.

¹⁸ Conner R, et.al., Ed., *Perioperative Standards and Recommended Practices*, Association of periOperative Registered Nurses, Vol. 1, 2013. Accessed on September 5, 2013.

surgery, anesthesia, and FMS. OR staff stated that the problem occurs most often in rooms with outside walls and that it seems to be a seasonal problem. Some nurses reported that they believe food is being consumed by EMS staff in the OR at night, which attracts insects. The facility does not have a policy addressing prevention or management of insect problems.

Conclusions

We found that cleanliness of the OR could not be assured due to inadequate staff resources, incomplete and inconsistent SOPs, poor supervision and training of EMS staff, and lack of oversight.

We initially found that safeguards were inadequate for ensuring patient and employee safety when infectious patients who may require isolation precautions were scheduled for OR procedures concurrently with noninfectious patients. However, by the time of our hotline site visit, the facility had made improvements and was in the final process of updating policies and procedures. During the course of our review, we also identified weaknesses in the environment of care process related to the HVAC system maintenance and insect control to the OR.

Although our findings substantiated an increased risk to patients and staff, our review of Infection Control Committee minutes and quality assurance reports found no conclusive evidence that the environment of care deficiencies in the OR resulted in negative patient outcomes.

Recommendations

1. We recommended that the Facility Director strengthen policies and procedures related to the operating room environment of care to be consistent with recognized industry standards.
2. We recommended that the Facility Director develop and implement policies and procedures to address management of infectious patients in the operating room; Heating, Ventilation, and Air Conditioning system preventive maintenance; and insect control in the operating room.
3. We recommended that the Facility Director reassess Environmental Management Services staffing needs in the operating room and assign personnel requisite to the workload on each shift.
4. We recommended that the Facility Director ensure that Environmental Management Services staff and supervisors receive training on operating room environment of care requirements, especially terminal cleaning.
5. We recommended that the Facility Director implement procedures to monitor the operating room environment of care and to address identified deficiencies.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: January 21, 2014

From: Director, VA New England Healthcare System (10N1)

Subject: **Healthcare Inspection—Environment of Care Deficiencies in the Operating Room, VA Connecticut Healthcare System, West Haven, CT**

To: Director, Bedford Office of Healthcare Inspections (54BN)

I have reviewed and concur with the action plans regarding the Draft Report – Environment of Care Deficiencies in the Operating Room, VA Connecticut HCS.

Sincerely,

(original signed by:)

Michael Mayo-Smith, MD, MPH
Network Director

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: January 16, 2014

From: Director, VA Connecticut Healthcare System (689/00)

Subject: **Healthcare Inspection—Environment of Care Deficiencies in the Operating Room, VA Connecticut Healthcare System, West Haven, CT**

To: Director, VA New England Healthcare System (10N1)

I have reviewed and concur with the action plans regarding the Healthcare Inspection – Environment of Care Deficiencies in the Operating Room, VA Connecticut Healthcare System, West Haven, CT.

Sincerely,

(original signed by:)

Gerald Culliton
Facility Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director strengthen policies and procedures related to the operating room environment of care to be consistent with recognized industry standards.

Concur

Target date for completion: 02/28/2014

Facility response: VA Connecticut addressed the recommendation with key stakeholders including the Associate Director, Chief of FMS, EMS Supervisor, Infection Control, and the Operating Room Leadership. Revisions were begun to policies and procedures related to the operating room environment of care immediately following the site visit. Operating room checklists were developed by Infection Control and EMS Leadership to help standardize EMS cleaning, and towards educating staff on the differentiation of terminal and between-case cleaning. The checklist was also optimized to reinforce the daily responsibilities for terminal cleaning. A consultative site visit is scheduled for the week of January 20th, 2014 during which the Acting EMS Chief and Nurse Epidemiologist from the VA Boston Healthcare System will evaluate EMS operations, staffing, and policies related to the Operating Room. Further revisions to policies and procedures will be completed based on the recommendations of the site visitors and will be implemented by 02/28/2014. Daily monitoring of the OR Environment of care using a standardized checklist has been implemented at the beginning of each scheduled OR day and is reported daily to the Director's Office for monitoring and further action as needed. Results of this monitoring including the tracking of open issues to closure will occur weekly with the Executive Team and will be reported monthly to the OR Management and Environment of Care Committees.

Recommendation 2. We recommended that the Facility Director develop and implement policies and procedures to address management of infectious patients in the operating room; Heating, Ventilation, and Air Conditioning system preventive maintenance; and insect control in the operating room.

Concur

Target date for completion: 03/15/2014

Facility response: VA Connecticut addressed the recommendation with key stakeholders including the Associate Director, Chief of FMS, EMS Supervisor, Infection Control, and the Operating Room Leadership. During the site visit, VA Connecticut revised the SOP for management of infectious patients in the operating room. If

feasible, effort will be made to schedule patients on contact or other isolation status at the end of the elective schedule. Specific precaution signage for use through the peri-operative period have been implemented and are specific to the type of precautions required for an individual patient. A visual marker has been added to the front of the procedure name in the surgical scheduling package to facilitate communication of the need for precautions. MRSA nasal swabs are now obtained during pre-anesthesia clinic visits to enhance early detection of resistant *S. aureus*, allowing for advance notification of OR/PACU staff and sooner placement in appropriate precautions. Compliance with the policy will be monitored by the OR Nurse Manager. A policy and procedure for Heating, Ventilation, and Air Conditioning system preventative maintenance specific for the Operating Room is being developed and will be finalized after the site visit (noted above) is complete with implementation no later than 02/28/2014. Daily monitoring of the HVAC system will occur via a daily checklist process described under recommendation 1. Monitoring will occur via reporting to the OR Management and EOC Committee quarterly. A policy and procedure for insect control specific for the Operating Room is being developed and will be finalized after the site visit (noted above) is complete with implementation no later than 03/15/2014.

Recommendation 3. We recommended that the Facility Director reassess Environmental Management Services staffing needs in the operating room and assign personnel requisite to the workload on each shift.

Concur

Target date for completion: 02/28/2014

Facility response: VA Connecticut addressed the recommendation with key stakeholders including the Associate Director, Chief of FMS, and the EMS Supervisor. Current staffing levels were evaluated and adjusted to include an additional FTE on both the day and evening shifts. All of these positions are currently filled. In addition, four additional EMS supervisors have been hired. Staffing levels will be evaluated during the site visit (noted above) and adjusted further as needed with implementation no later than 02/28/2014. Monitoring of staffing levels for OR EMS Staffing will occur via daily review by the EMS Chief. Monitoring will be reported weekly to the Associate Director.

Recommendation 4. We recommended that the Facility Director ensure that Environmental Management Services staff and supervisors receive training on operating room environment of care requirements, especially terminal cleaning.

Concur

Target date for completion: 03/15/2014

Facility response: VA Connecticut addressed the recommendation with key stakeholders including the Associate Director, Chief of FMS, EMS Supervisor, Infection Control, and the Operating Room Leadership. Reeducation regarding operating room environment of care requirements including terminal cleaning was provided to EMS staff

working in the OR as well as supervisors and will be completed after the final policies and procedures referred to under recommendation #1 are completed. VA Connecticut has created a full time FTE for an RN Educator based in the Hospital Education Service to be the dedicated EMS educator and will oversee the training and competency evaluation of all EMS staff. This position is in the final stages of recruitment. Monitoring will occur on a quarterly basis to ensure that all EMS staff working in the OR or supervising those working in the OR are current on their training and competency requirements.

Recommendation 5. We recommended that the Facility Director implement procedures to monitor the operating room environment of care and to address identified deficiencies.

Concur

Target date for completion: 01/15/2014

Facility response: Daily monitoring of the OR Environment of care using a standardized checklist has been implemented at the beginning of each scheduled OR day and is reported daily to the Director's Office for monitoring and further action as needed. Results of this monitoring including the tracking of open issues to closure will occur weekly with the Executive Team and reported monthly to the OR Management and Environment of Care Committee. Monitoring will occur via the review of the standing agenda item inclusion and minutes beginning with the February meetings of both OR Management and EOC Committees.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Frank Keslof, EMT, MHA, Team Leader Annette Acosta, RN, MN Thomas Jamieson, MD Matt Frazier, MPH, MBA

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA New England Healthcare System (10N1)
Director, VA Connecticut Healthcare System (689/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and
Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and
Senate Committee on Homeland Security and Governmental Affairs
Related Agencies
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Richard Blumenthal, Christopher Murphy
U.S. House of Representatives: Rosa L. DeLauro, John B. Larson

This report is available on our web site at www.va.gov/oig