

GAO Highlights

Highlights of [GAO-18-474](#), a report to the Chairman, Committee on Veterans' Affairs, House of Representatives

Why GAO Did This Study

VHA operates one of the largest health care delivery systems in the nation, serving over 9 million enrolled veterans. In providing health care services to veterans, VAMCs use RME which must be reprocessed—that is, cleaned, disinfected, or sterilized—between uses. Improper reprocessing of RME can negatively affect patient care. To help ensure the safety of veterans, VHA policy establishes requirements VAMCs must follow when reprocessing RME and requires a number of related oversight efforts.

GAO was asked to review VHA's reprocessing of RME. This report examines (1) VHA's oversight of VAMCs' adherence to RME policies and (2) challenges VAMCs face in operating their Sterile Processing Services programs, and any efforts by VHA to address these challenges. GAO reviewed relevant VHA documents including RME policies and VISN inspection results for fiscal year 2017. GAO interviewed officials from VHA, all 18 VISNs, and four VAMCs, selected based on geographic variation, VAMC complexity, and data on operating room delays. GAO examined VHA's oversight in the context of federal internal control standards on communication, monitoring, and information.

What GAO Recommends

GAO is making three recommendations to VHA, including that it ensure all RME inspections are being conducted and complete results reported, and that it examine Sterile Processing Services workforce needs and make adjustments, as appropriate. VA concurred with these recommendations.

View [GAO-18-474](#). For more information, contact Sharon Silas at (202) 512-7114 or silass@gao.gov.

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VA HEALTH CARE

Improved Oversight Needed for Reusable Medical Equipment

What GAO Found

GAO found that the Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) does not have reasonable assurance that VA Medical Centers (VAMC) are following policies related to reprocessing reusable medical equipment (RME). Reprocessing involves cleaning, sterilizing, and storing surgical instruments and other RME, such as endoscopes. VHA has not ensured that all VAMCs' RME inspections have been conducted because it has incomplete information from the annual inspections by Veterans Integrated Service Networks (VISN), which oversee VAMCs. For fiscal year 2017, VHA did not have 39 of the 144 VISN reports from the VISNs' inspections of their VAMCs' Sterile Processing Services departments. VISNs were able to provide GAO with evidence that they had conducted 27 of the 39 missing inspections; top areas of non-adherence in these inspections were related to quality and training, among other things. Although VHA has ultimate oversight responsibility, a VHA official told GAO that VHA had not been aware it lacked complete inspection results because it has largely relied on the VISNs to ensure complete inspection result reporting. Without analyzing and sharing complete information from inspections, VHA does not have assurance that its VAMCs are following RME policies designed to ensure that veterans receive safe care.

An endoscope is a kind of reusable medical equipment



Source: Image of endoscope reprinted with permission from Ofstead & Associates, Inc. | GAO-18-474

GAO also found that VAMCs face challenges operating their Sterile Processing Services programs—notably, addressing workforce needs. Almost all of the officials from all 18 VISNs and selected VAMCs GAO interviewed reported Sterile Processing Services workforce challenges, such as lengthy hiring timeframes and limited pay and professional growth potential. According to officials, these challenges result in programs having difficulty maintaining sufficient staffing. VHA officials told GAO that the office is considering studying Sterile Processing Services staffing at VAMCs, although VHA does not have definitive plans to do so. VHA's Sterile Processing Services workforce challenges pose a potential risk to VAMCs' ability to ensure access to sterilized medical equipment, and VHA's failure to address this risk is inconsistent with standards for internal control in the federal government. Until VHA examines these workforce needs, VHA won't know whether or to what extent the reported challenges adversely affect VAMCs' ability to effectively operate their Sterile Processing Services programs and ensure access to safe care for veterans.