

specifically told to use the sanitizing cloths to clean laryngoscopes. She did not observe a laryngoscope being cleaned. This nurse further stated that, after asking staff from the Medical College of Georgia how laryngoscopes were cleaned there, expressed concerns to the ENT Clinic Chief and Chief of SPD in June or July 2008.

In addition to an epidemiologist's investigation, medical center managers also directed the Risk Manager and Quality Manager to investigate staff actions, and chartered a Root Cause Analysis (RCA) team to evaluate system and process issues that could have contributed to the event. Those reports were submitted on February 11 and March 4, respectively.

Prior to the November 4 event, FFE reprocessing SOPs had not been updated since 2001; in addition, staff responsible for FFE reprocessing did not have adequate documentation of competence assessments. When we visited Augusta in May 2009, the facility still did not have documentation of device-specific competence, which was the standard used in this national assessment.

## **Section II – National Assessment of Reprocessing Practices in VHA**

### **Scope and Methodology**

We reviewed applicable regulations, policies, procedures, and guidelines. Twenty-six inspectors conducted unannounced onsite visits for the total of 42 probability-based randomly selected VHA facilities to examine pertinent endoscope reprocessing documentation.

To prepare for the unannounced onsite inspection, we emailed a request to the directors of VHA facilities for information on colonoscopy and ENT endoscopy on April 27, 2009. This request asked for the following information: (1) a list of the manufacturer and model number for each colonoscope in active use at each procedure location and reprocessing location, including clinics, (2) reprocessing locations for ENT endoscopes, including clinics, and (3) the administrative section responsible for completing performance evaluations for HLD staff at each reprocessing location.

### **Study Populations**

The study population for colonoscope (or ENT endoscope) reprocessing consisted of all colonoscope (ENT endoscope) HLD reprocessing units in VHA facilities as of April 27, 2009. A VHA facility may have more than one endoscope reprocessing location, and each of the reprocessing units was counted. For example, a facility may reprocess colonoscopes both in its GI procedure suite/room and at its OR, and thus two HLD reprocessing units would be counted for that facility. In addition, a facility may send its