Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center New Orleans, Louisiana

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VA Office of Inspector General
Washington, DC 20420

Office of Inspector General
Combined Assessment Program Reviews

Combined Assessment Program (CAP) reviews are part of the Office of Inspector General's (OIG's) efforts to ensure that high quality health care and benefits services are provided to our Nation's veterans. CAP reviews combine the knowledge and skills of the OIG's Offices of Healthcare Inspections, Audit, and Investigations to provide collaborative assessments of VA medical facilities and regional offices on a cyclical basis. The purposes of CAP reviews are to:

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Conduct fraud and integrity awareness training for facility staff.

In addition to this typical coverage, CAP reviews may examine issues or allegations referred by VA employees, patients, Members of Congress, or others.

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Executive Summary

Introduction

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center (VAMC), New Orleans, Louisiana during the week of November 18, 2002. The purpose of the review was to evaluate selected medical center operations focusing on patient care administration, quality management (QM), and financial and administrative management controls. During the review, we also provided fraud and integrity awareness training to 183 medical center employees.

Results of Review

The VAMC's management of waiting lists and patient waiting times was adequate. The VAMC's Patient Advocate Program was responsive and sensitive to veterans' and families' needs in resolving complaints regarding patient care-related issues. In addition, VAMC managers had an effective program to control access to the facility and to identify all persons on the premises. To improve operations, the Veterans Integrated Service Network (VISN) 16 Director needed to ensure that the Medical Center Director:

- Increases purchase card utilization and strengthens controls over the program.
- Corrects deficiencies in automated information systems (AIS) security.
- Strengthens procedures for the management of violent patients.
- Strengthens research laboratory security.
- Assures that charges for the Picture Archiving and Communication (PAC) System maintenance and repair services are verified against contracted rates.
- Improves the management of controlled substances and physical security of the Outpatient Pharmacy.

We also made suggestions regarding the environment of care.

VISN and VAMC Directors' Comments

The VISN and VAMC Directors agreed with our findings and recommendations and provided acceptable implementation plans. (See Appendices A, B, and C, pages 15-26, for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

(Original signed by:)
RICHARD J. GRIFFIN
Inspector General

Introduction

VA Medical Center Profile

Organization. The New Orleans VAMC is a tertiary care medical center that provides a broad range of inpatient and outpatient healthcare services. Outpatient care is also provided at a community-based outpatient clinic (CBOC) located in Baton Rouge, Louisiana. The VAMC is part of VISN 16 and serves a population of about 222,000 veterans in a primary service area that covers 23 parishes in southeast Louisiana.

Programs. The VAMC provides medical, surgical, mental health, geriatric, and rehabilitation services. The medical center has 146 acute care beds and 60 extended care beds, and operates several referral and treatment programs. The VAMC also has nine sharing agreements for clinical services and training with Department of Defense (DoD) providers.

Affiliations and Research. The medical center is affiliated with the Tulane University and Louisiana State University Schools of Medicine, and supports 529 medical resident positions in 29 training programs. The medical center also has affiliations for nursing and allied health training programs with 10 additional colleges and universities. In Fiscal Year (FY) 2002, the medical center's research program had 120 projects and a budget of $2 million. Important areas of research included endocrine peptides, cancer, and brain injury.

Resources. In FY 2002, medical care expenditures totaled more than $187 million. The FY 2003 medical care budget is $198.2 million. FY 2002 staffing totaled 1,544 full-time equivalent employees (FTEE), including 99.7 physician and 261.5 nursing FTEE.

Workload. In FY 2002, the medical center treated 36,079 unique patients. The medical center provided 31,161 days of care in the hospital and 18,828 days of care in the Nursing Home Care Unit. The inpatient care workload totaled 4,860 discharges, and the average daily census, including nursing home patients, was 137. The outpatient workload was 370,902 visits.

Objectives and Scope of CAP Review

Objectives. CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA healthcare services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected medical center operations focusing on patient care, QM, and financial and administrative controls.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and of the need to refer suspected fraud to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and general management controls. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Patient care administration is the process of planning and delivering patient care. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered selected aspects of the following activities and programs:

Quality management	Government Purchase Card Program
Management of violent patients	AIS security
Environment of care	Laboratory security
Controlled substances	Contract award and administration
Outpatient pharmacy security	Patient waiting times
Visitor identification program	Patient Advocate Program

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of services and the quality of care. We sent electronic survey questionnaires to VAMC employees, 293 of whom responded. We also interviewed 65 patients during our review. The surveys indicated high levels of patient satisfaction and moderate levels of employee satisfaction. We provided the survey results to VAMC management.

During the review, we also presented four fraud and integrity awareness briefings for VAMC employees. These briefings, attended by 183 employees, covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, false claims, conflicts of interest, and bribery.

The review covered VAMC operations for the period January 1999 through October 2002, and was done in accordance with OIG standard operating procedures for CAP reviews.

In this report, we make both recommendations and suggestions for improvements. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. Suggestions pertain to issues that should be monitored by VISN or VAMC management until corrective actions are completed.

Results of Review

Organizational Strengths

Management of Waiting List and Patient Waiting Times. The medical center used the Veterans Health Information System and Technology Architecture (VISTA) system and reports on patient waiting times to monitor and control the waiting lists. Veterans who enrolled but did not request immediate appointments were entered on the inactive waiting list. Veterans who required appointments were placed on the active waiting list when appointments were not available. At the time of our review, the medical center did not have any patients on the active waiting list.

Except for Ophthalmology Clinic, which had a backlog of about 60 days, patients requiring routine, follow-up, and specialty consultations were given appointments within 30 days, as required by Veterans Health Administration (VHA) performance goals for Primary Care and high use specialty clinics. We reviewed medical records for 20 randomly selected patients and found that all 20 were scheduled for appointments within the required time frame. We attributed this success to the medical center's implementation of procedures recommended by the Institute for Healthcare Improvement. These procedures included panel[1] scrubbing (purging physicians' assigned patients to delete patients who no longer required care), establishing an Urgent Care Clinic to manage walk-in and emergency care patients, and implementing a specialty authorization program to assist specialists in managing their time.

The panel scrubbing process was designed to improve access for new patients waiting for initial appointments with primary care providers. The medical center instituted a weekly schedule for scrubbing panels. Patients who had not required an appointment within 2 years, and those who had moved or died were removed from the panels and replaced with new patients from the active waiting list.

The medical center also established an Urgent Care Clinic. Nurse practitioners and physician assistants generally staffed this clinic. The main purpose of the clinic was to increase patients' access to primary care providers by managing walk-ins. It also ensured that patients who needed immediate care received care promptly.

The specialty authorization program is an electronic tool that allows for optimal use of a specialist's time. When a consultation was approved for a specialty evaluation, the patient received a specialty-specific electronic authorization. This authorization was required for an appointment to be made for the needed specialty. After the specialist completed an episode of evaluation and treatment and discharged the patient, this electronic authorization was discontinued and the appointment management system did not allow further appointments. If the patient needed to be referred again to the specialty, another consultation had to be initiated. However, if the patient needed to be followed indefinitely by the specialist, authorization was not discontinued and future appointments were made without additional consultations. According to

[1] A panel is a group of patients assigned to a specific primary care provider.

medical center managers, this program improved access to specialists by 3-5 percent, and helped many specialty clinics meet or exceed the 30-day performance goal for an appointment.

Patient Advocate Program. The Patient Advocate Program was responsive and sensitive to veterans' and families' needs in resolving complaints regarding patient care-related issues. The program utilized Customer Service Coordinators (CSC) appointed to serve as liaisons for their respective Service Lines or Corporate Functions. Problems that might be resolved quickly were referred by the Patient Advocate to the CSC for the involved Service Line or Corporate Function. Therefore, customers received immediate resolutions to their problems from individuals in the areas where the problems occurred.

Any complaint of rudeness or lack of courtesy generated a letter of apology to the patient by the Medical Center Director. Substantiation of the allegation was not a prerequisite for the generation of the apology, as the patient's perception of rudeness was acknowledged. Patient advocate complaints were reported daily to top management and complaint data was shared regularly with the unions, veterans service organizations, the leadership team, and service line managers.

Visitor Identification Program. The VAMC had an effective program to control access to the facility and to identify all persons on the premises. Every person entering the facility presented photographic identification to Police and Security Service employees. Employees were required to wear VAMC identification badges. Non-employees, including outpatients, vendors, and visitors received temporary date-stamped identification badges and signed a logbook stating their destination and the purpose of their visit. Vendors had to have scheduled appointments with employees and be escorted to their destinations.

Opportunities for Improvement

Government Purchase Card Program – Purchase Card Utilization Needed to be Increased and Program Controls Strengthened

Conditions Needing Improvement. Our review of the medical center's Government purchase card transactions during the period October 1, 2001 through September 30, 2002, showed that cardholders made 16,984 purchase card transactions totaling about $10.1 million. Management needed to correct program deficiencies in four areas:

The Government Purchase Card Program Was Underutilized. Government purchase cards were not used to the maximum extent practicable. The medical center used certified invoices instead of purchase cards to make purchases totaling about $59 million. The medical center would have received about $630,000 in rebates from the purchase card contractor by using Government purchase cards instead of certified invoices for these transactions. Additionally, warrants and purchase card limits for purchasing agents were too low, and some contracting specialists did not have purchase cards. VHA requires that warranted individuals, such as contracting specialists and purchasing agents, use Government purchase cards as the preferred method of payment. Our review of medical center purchase card transactions showed that all transactions were for less than $10,000. The Materials Management Service Line Director told us that she thought the single purchase limit for the purchasing agents was greater than $10,000. She agreed to increase the single purchase limits for the purchasing agents and initiate action to provide contracting specialists with purchase cards.

Cardholders Split Purchase Card Transactions to Stay Within Their Single Purchase Limits. We found that 2 purchase cardholders split 10 purchase orders totaling $49,950 to stay within their single purchase limits of $5,000 and $10,000 respectively. Approving officials did not monitor cardholders' purchases to ensure that they stayed within their purchase limits, as required by VHA policy.

Purchase Card Transactions Were Not Approved Timely. Cardholders did not always complete all required certifications of purchase card transactions necessary to electronically transmit them to approving officials. Consequently, some transactions were not approved timely. During the period of our review, we identified 228 purchase card transactions valued at about $137,625 that were not approved timely. The approvals ranged from 15 to 350 days after the reconciliation dates, with an average of 105 days. Approving officials are required to certify purchase card transactions in the Integrated Funds Distribution, Control Point Activity, Accounting, and Procurement (IFCAP) System within 14 days of receipt from the cardholders.

Complete and timely reconciliations, certifications, and approvals of transactions are necessary because VA has only 60 days to dispute erroneous charges with Citibank. When transactions were not approved timely, facility managers had no assurance that items purchased were actually received or that purchases were for official VA purposes.

Quarterly Audits of Cardholders' Accounts Were Not Conducted. Quarterly audits of cardholders' accounts had not been conducted at the medical center since the Government

Purchase Card Program was initiated in 1995. Quarterly audits are required of all cardholder accounts that are not reviewed during monthly statistical sampling audits conducted by the VA Financial Service Center (FSC). Some of the deficiencies identified during our review could have been detected and/or prevented through these quarterly audits.

Recommended Improvement Action 1. We recommended that the VISN Director ensure that the VAMC Director require that:

a. Purchase card limits for purchasing agents are increased as appropriate.
b. Purchase cards with appropriate single purchase limits are issued to contracting officers.
c. Purchase cards are used to purchase equipment and services that exceed $10,000.
d. Cardholders complete the required certifications during the reconciliations of purchase card transactions, and approving officials approve reconciled transactions more timely.
e. Quarterly audits are conducted of all purchase cardholder accounts not reviewed during the monthly audits conducted by the VA FSC.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plans. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Automated Information Systems Security – Deficiencies in Security Needed to be Corrected

Conditions Needing Improvement. Our review of the medical center's implementation of policies and actions taken to ensure AIS security showed the need for management attention in six areas to correct AIS security deficiencies:

Certifications of Major AIS were Needed. None of the major AIS, including VISTA, Local Area Network, Exchange, and Private Branch Exchange systems had been certified in accordance with VA policy. Certifications ensure that controls designed to ensure the security of AIS resources are in place and the systems are operating effectively. In order for certification to take place, each AIS must have a security plan, contingency plan, risk assessment, and a document detailing expected rules of behavior for system use. Without proper certifications, the Medical Center Director did not have assurance that controls were operating as intended.

Contingency Plans Were Not Comprehensive. The medical center's contingency plans generally did not:

- Identify a disaster recovery team and specify roles key personnel would play in the disaster recovery process.
- Identify an alternate processing facility that could be used during disaster recovery.
- Prioritize specific tasks and computer applications to be installed in a disaster recovery situation.
- Identify an off-site storage location for contingency plans.

VA policy requires facilities to develop and implement AIS contingency plans to reduce the impact of disruptions in services, provide critical interim processing support, and resume normal operations. Contingency plans that are not comprehensive are of limited use in catastrophic situations. The recovery process will be slowed and the delivery of essential health care could be affected.

Controls Over Granting Remote Access Needed Improvement. Our review of the medical center's procedures for granting and monitoring remote access to AIS showed that two areas needed management attention to improve controls:

- The Information Security Officer (ISO) and the Clinical Information Management Service Line did not maintain documentation justifying the need for remote access.
- Quarterly reviews of the continued need for remote access were not performed. Based on our review, the ISO terminated access for 44 of the 220 employees with remote access.

Without strong controls over remote access, overall system security is weakened, vulnerabilities are increased, and the medical center's AIS are susceptible to unauthorized access.

Security of AIS Back-Up Tapes Needed Improvement. Off-site storage of AIS back-up tapes did not provide adequate security. Back-up tapes were stored in commercially leased space in a locked file cabinet type container located in a room open to general access. Back-up tapes should be stored in a fireproof safe in an area with limited access. VA policy requires that AIS back-up tapes be stored in a secure location to ensure that they are safeguarded.

Procedures for Disposal of Equipment Containing Sensitive Information Lacked Accountability. Clinical Information Management Service Line managers did not document a designated official to certify that equipment with storage media was properly cleared (degaussed) of sensitive information before disposal. VA policy requires the assignment of an official to ensure that equipment with storage media is properly cleared before disposal.

Signs Identifying AIS Resources Needed to Be Removed. Signs identifying closets containing AIS telecommunication equipment needed to be removed. According to the network manager, there were 41 such closets located throughout the medical center. He agreed to remove all signs identifying these closets. The identification of AIS telecommunication equipment locations places AIS resources at risk for destruction.

Recommended Improvement Action 2. We recommended that the VISN Director ensure that the VAMC Director require that:

a. Major AIS are certified.
b. Contingency plans include all of the appropriate elements.
c. Continued need for remote access is reviewed quarterly.
d. AIS back-up tapes are stored in a fireproof safe with limited access.
e. An official is designated, in writing, to certify that AIS equipment is cleared of sensitive information.

f. Signs identifying the location of closets containing AIS telecommunication equipment are removed.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plans. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Management of Violent Patients – Critical Areas of the Program Needed Development

Conditions Needing Improvement. Our review of the medical center's program for preventing and managing violent incidents showed that managers did not consistently review such incidents, did not consistently identify violent patients, and did not consistently correct vulnerability deficiencies. In August 2001, the VHA Task Force on Workplace Violence concluded that essential components of an effective violence prevention program were not well developed or were missing entirely. A March 1996 Office Of Inspector General (OIG) report, 6HI-A28-038 (Evaluating VHA Policies and Practices for Managing Violent or Potentially Violent Psychiatric Patients), recommended actions to reduce the incidence of violence on inpatient psychiatry units. The OIG's September 30, 2002, Semiannual Report to Congress reported that the recommendation that VHA develop a computerized flagging system to alert all medical center employees when patients with violent behavior histories arrive for treatment, remained unimplemented. We reviewed the VAMC's procedures for preventing and managing patient violence and found the following areas needed improvement:

Violent Patient Incidents Were Not Consistently Reviewed. We reviewed 10 patient incidents involving violent behaviors and found that only 4 were forwarded to the Disruptive, Threatening, Violent Behavior (DTVB) Team. This team was responsible for oversight of the Prevention of Violence Program. This responsibility included: reviewing, tracking, and analyzing data; recommending action to the Director; and follow-up of recommended actions. Of the six cases that were not forwarded, one resulted in injuries to two nursing employees, both of whom filed workman's compensation claims. These claims represented 51 lost workdays, $6,584 paid in workman's compensation associated with the lost workdays, and $3,015 paid in medical expenses. Two other cases that were not forwarded to the team involved repeat offenders.

Violent Patients Were Not Consistently Identified. Our review showed that, due to the lack of consistency in reviewing all violent patient incidents, some patients whose records warranted a computerized warning were not flagged, creating potential safety risks for employees and other patients. Medical center policy COS-16, *Prevention and Management of Disruptive Behavior*, required that a patient's medical record be electronically flagged when that patient had a significant potential for violence. In our pre-site survey, 79 percent of employees who responded to the question (227 of 287) indicated that they had never encountered violent patient warning flags in the computerized patient records.

Warning Flags Were Not Visible to All Employees. Clerical employees who registered and scheduled patients were vulnerable to violent incidents. When a computerized alert flag was placed in a patient's medical record, it appeared only in the Computerized Patient Record System (CPRS). There was no similar process to place alerts into VISTA. Clinical employees are the primary users of CPRS, but clerical employees who register and schedule patients for appointments use VISTA exclusively. These employees need to know when a patient with a potential for physical violence presents for treatment.

Safety and Vulnerability Deficiencies Were Not Corrected. According to the Police and Security Service Management Plan, Police were responsible for completing annual facility safety and security vulnerability inspections. Medical center Police and Security Service officers completed these assessments and reported deficiencies to service chiefs who were responsible for corrective action. Managers had not established procedures to ensure that recommendations were implemented. Consequently, the same safety and vulnerability deficiencies continued from year to year.

Employees Expressed Concerns About Their Safety. In response to questions from the Management of Violent Patients section of the employee survey, 39 percent (113 of 287) of employees responding indicated that they did not feel protected against potentially violent patient incidents in their work environment. Employees' comments expressed a need for more frequent police patrols of the facility, feelings of vulnerability to violence due to design of their workspaces, and a desire for more surveillance cameras and panic buttons. We discussed these survey results with the Chief, Police and Security Service and senior managers. They indicated that they would consider options to address employees' concerns.

Recommended Improvement Action 3. We recommended that the VISN Director ensure that the VAMC Director:

a. Require that all incidents of patient violence be forwarded to the DTVB Team for evaluation and appropriate action.
b. Develop a process to place computerized flags into VISTA and CPRS simultaneously.
c. Establish procedures to assure the implementation of recommendations that result from the annual safety and vulnerability assessment.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plans. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Research Laboratory Security – Laboratory Access Needed Improvement

Condition Needing Improvement. Housekeeping personnel had access to sensitive research laboratory areas and performed their duties when research laboratory employees were not present. VHA headquarters directed facility managers to strengthen physical security in research

and clinical laboratories after September 11, 2001, and the VHA Office of Research and Development provided facilities the opportunity to submit applications for the purchase of equipment to enhance the current levels of security for research laboratories and animal facilities located within VA medical centers. Medical center managers applied for this funding and received $20,000 to install an electronic access control security system throughout the Research Service. Although this research facility had no biosafety level 3 laboratories, and did not store or use sensitive or select agents, the presence of an animal care facility and the presence of the VA's only active Nobel Laureate made the Research Laboratory a high security risk.

Police and Security Service performed annual Safety/Vulnerability Assessments of areas in the facility that were considered sensitive. The Chief, Police and Security Service told us that housekeeping personnel did not have unsupervised access to other sensitive areas after regular tour hours. Research Service could further enhance its security by limiting access to housekeeping personnel to hours when research personnel are present.

Recommended Improvement Action 4. We recommended that the VISN Director ensure that the VAMC Director require that access for routine cleaning of the Research Service laboratories be limited to hours when research employees are present.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plans. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Contract Award and Administration – Charges for Services Needed to be Verified Against Contracted Rates

Condition Needing Improvement. The medical center paid higher than contracted rates for maintenance and repair of the medical center's PAC System. This occurred because the contracting officer's technical representative (COTR) did not verify the rates billed with the contracted rates. Review of six bills showed that the medical center overpaid the contractor $1,295 for services. The contractor's representative agreed that the medical center was charged rates higher than the contract rates. The representative also agreed to review all billings since the inception of the contract in January 1999, to determine the total amount of excessive charges to be refunded to the medical center. Additionally, the medical center's Materials Management Service Line Director agreed to conduct an independent review of all bills paid since the inception of the contract to verify that the refunded amount is correct.

Recommended Improvement Action 5. We recommended that the VISN Director ensure that the VAMC Director require that:

a. All bills for the PAC System maintenance and repair contract are reviewed and overcharges are collected from the contractor.
b. COTRs verify contractor bills to ensure that the rates billed are consistent with contract rates.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plans. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Controlled Substances Security – Management of Controlled Substances and Physical Security of the Outpatient Pharmacy Needed to be Improved

Conditions Needing Improvement. Pharmacy Service controls over controlled substances and outpatient pharmacy security needed to be improved by:

Conducting Inventories of Controlled Substances Every 72 Hours. Our review of inventory records for 66 controlled substances showed that physical counts to verify perpetual inventories were not completed every 72 hours. VA policy requires that Pharmacy Service verify its stock of controlled substances at a minimum of every 72 hours. The time between inventories ranged from 4 to 14 days, and averaged 7 days.

Comparing Controlled Substances Inventory Records With Receiving Reports. Inspection officials did not include a comparison of receiving reports with Pharmacy Service controlled substances inventory records during monthly, unannounced controlled substances inspections. Comparing inventory records with receiving reports operates as an internal control to prevent the diversion of controlled substances.

Timely Disposition of Expired or Unusable Controlled Substances. Our review of controlled substances disposal records at the Baton Rouge CBOC showed that 3 years had passed between the last disposal in July 1999, and the most recent disposal in July 2002. VA policy requires that expired or unusable controlled substances be disposed of quarterly. The timely disposition of expired or unusable controlled substances is essential to prevent excessive stock accumulations and significantly reduces the potential for diversion.

Installing a Local Sounding Alarm on the Intrusion Detector in the Outpatient Pharmacy. The medical center's Police and Security Service recommended in December 2001, and again in October 2002, that a local sounding alarm be installed on the intrusion detector in the outpatient pharmacy. The alarm had not been installed at the time of our visit. VA physical security requirements include installation of an intrusion detection alarm system that detects entry into the room and broadcasts a local alarm of sufficient volume to cause an illegal entrant to abandon a burglary attempt.

Recommended Improvement Action 6. We recommended that the VISN Director ensure that the VAMC Director require that:

a. Inventories of controlled substances are verified every 72 hours.
b. Receiving reports are compared with Pharmacy Service controlled substances inventory records during monthly, unannounced controlled substances inspections.

c. Expired or unusable controlled substances are disposed of quarterly.
d. A local sounding alarm is installed on the intrusion detector in the outpatient pharmacy.

The VISN and VAMC Directors agreed with the findings and recommendations, and the VISN Director concurred with the VAMC Director's corrective action plans. The VAMC Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Environment of Care – Several Areas Required Management Attention

Conditions Needing Improvement. We found several safety problems involving the security of hazardous cleaning supplies, crash carts, and patient nourishment refrigerators. Several areas of the medical center were not clean and needed maintenance and repair, including the Veterans Canteen Service (VCS) dining room and food preparation areas, an inpatient ward, and the Food and Nutrition Service (F&NS) kitchen. Of 276 employees who responded to the pre-site survey question, 112 (41 percent) felt that housekeeping support was not adequate to maintain patient safety and general cleanliness, and 52 percent said that work orders were not promptly completed.

To assess the safety and cleanliness of the medical center, we inspected a medical ward (5B), a surgical ward (7C), a medicine/intermediate care ward (7B), a psychiatric ward (8C), the Surgical Intensive Care Unit (SICU), the Cardiac Care Unit (CCU), the Medical Intensive Care Unit (MICU), the Hemodialysis Unit (HDU), the Post Traumatic Stress Disorder Residential Unit (PTSDRU), the Women's Center, three outpatient clinics (Pulmonary, Urgent Care, and Mental Health-Ambulatory Care), the Emergency Room (ER), and ancillary and support areas. We also inspected the F&NS kitchen, and all VCS areas. We toured with the managers of each area we inspected, and we identified areas that were unsafe, unclean, or had potential infection control problems.

Safety Issues Needed to be Addressed. During our review, we identified the following safety conditions:

- A cleaning cloth in a bucket of dirty water and three spray bottles of cleaner used to clean tables were kept on top of the trash and tray receptacle in the VCS dining room. Easily accessible, hazardous cleaning supplies could lead to injury of patients or visitors.
- Outdated crash carts were found in the Urgent Care and Pulmonary Clinics.
- Employees did not inspect crash carts during every shift on the PTSDRU and on ward 7B.
- Some patient nourishments had expired on wards 7B, 7C, 5B, the PTSDRU, the SICU, the CCU, and the MICU.
- Open containers of milk were stored in dirty refrigerators on wards 7B, 7C, 5B, the PTSDRU, the SICU, the CCU, and the MICU.
- Wire racks for holding laundry bags were broken.

- Broken floor tiles between the two VCS serving lines and the threshold between the VCS kitchen and the VCS storage area presented a tripping hazard.

The Psychiatric Unit (Ward 8C) Needed Cleaning. As indicated above, we inspected more than 13 patient care areas and found them to be generally clean. However, cleanliness on psychiatric unit 8C needed to be improved. The waxed floor in the central living area was partially stripped and, according to the nurse manager, had been in that condition for several weeks. Although patients' bedrooms were generally acceptable, we found that patients' bathrooms on 8C were not clean. Bathroom floor tile grout was discolored and there was a film on tile walls. Windowpanes and flat surfaces were dusty and marked with handprints. We discussed the condition of 8C with Environment of Care Service Line managers who agreed with our findings and told us they would correct the deficiencies.

The F&NS Kitchen Needed Cleaning and Repair. The overall appearance of the F&NS kitchen was acceptable; however, we found:

- Dirty floors around the cooking area and the refrigerator.
- Several broken or missing floor tiles in the cooks' area.
- Several stained kitchen ceiling tiles and multiple missing ceiling tiles in the canned goods storage room.
- An entire wall covered in plastic from a completed construction project, and another wall with exposed metal ductwork in the canned goods storage room.

The VCS Environment Needed Improvement. We toured the VCS dining room, food preparation area, storage room, and employee locker rooms and found:

- Dirty tabletops and torn cushions in the seating units of the dining room.
- Uncovered trash containers in the food preparation area**.**
- Soiled and water-stained ceiling tiles in the dining room and employee locker rooms; and several water stained ceiling tiles and one missing ceiling tile in the VCS storage room.
- Grime and debris on floor edges in the food preparation area, dining room, and storage room and around furniture in the dining room and shelving in the storage room.
- Dried food spills on rusted shelves in the storage room; with shelves two inches from the floor instead of six inches as required.
- A dirty film on all walls, and dirt accumulation in the grout in the employee locker rooms.
- Malfunctioning toilet in the female employees locker room.

Canteen managers touring the VCS with us told us that replacement lockers for the employees locker rooms had already been requested and that they would submit an immediate work order for the plumbing problem. We were also informed that the VCS was scheduled for renovation in January 2003.

Suggested Improvement Action. We suggested that the VISN Director ensure that the VAMC Director take action to correct these deficiencies.

The VISN and VAMC Directors agreed with the findings and suggestion, and the VISN Director concurred with the VAMC Director's corrective action plans. The VAMC Director provided acceptable improvement plans.

Appendix A

December 12, 2002, Facility Status Report

The VAMC Director provided this interim status report in response to the findings presented to management at our exit conference. The status report describes corrective actions VAMC managers implemented to resolve issues identified during the CAP site visit.

Combined Assessment Program Review
VA Medical Center New Orleans, LA
November 18-22, 2002

Findings

Automated Information Security

Contingency plans are not comprehensive and did not identify:

- **A disaster recovery team.**
- **Roles team members would play during disaster recovery.**
- **Address the resumption of operations at an alternate processing site.**
- **Specific tasks and computer applications to be installed during recovery.**
- **The off station storage location of the contingency plans.**

VAMC New Orleans plans have been reviewed, audited, and approved on several levels. Our plans are living documents, which have evolved over years of experience, new technology, and new security challenges, and are revised and modified as needs arise. We appreciate the close review of the IG team, in further identifying additional components of our plans that might enhance their usability and strengthen their value. The VISTA Contingency Plan offers the most comprehensive outline of processes, responsibilities and procedures. The LAN, Exchange, and Telecommunications plans provide for a sound contingency, but did not reflect a more comprehensive explanation. All plans have been modified as follows in compliance with IG recommendations.

A disaster recovery team. All plans describe the operations and processes required for the contingency and the CIO as the responsible official for disaster recovery. The VISTA contingency lists individuals responsible for taking part in the contingency. The designation of a disaster recovery team has been added to all plans. The Team has been trained in their role specific duties by the CIO and the ISO.

Roles team members would play during disaster recovery. All plans describe processes to be implemented for disaster recovery and the roles of the CIO. The VISTA contingency describes the roles of top management, ISO, Service Line Directors, CIO, and ITACs. Specific roles for the disaster recovery team have been added to all plans. Updated contingency plans have been communicated to staff.

Address the resumption of operations at an alternate processing site. All plans provide for procedures to follow to restore services. In the event of a total site disaster, resumption of operations at an alternate processing site has been added to all plans.

Specific tasks and computer applications to be installed during recovery. Contingency plans currently provide instructions for restoration of hardware and software. Additions have been made to each plan to clarify tasks and computer applications or equipment to be installed during recovery.

The off station storage location of the contingency plans. The VISTA contingency plan identifies the off station storage area of backup disks, computer operations and users manuals, copies of hardware maintenance agreements, copies of software licensing agreements, VISTA equipment inventory, and copies of the contingency plans. Copies of these same elements have been added to the LAN, Exchange, and Telecommunications plans along with the location of the off-site storage. Also, copies of the documentation have been placed at the off-station site for safekeeping.

- **There are no AIS security plans for the major systems**.

Security plans were submitted in the format required by the IG. Copies of the Exchange, LAN, PBX and VISTA security plans were completed and given to the IG reviewer, on November 20, 2002.

- **Backup tapes were not stored in fireproof container accessible by only designated personnel.**

Backup tapes for all contingency plans are currently stored in a metal cabinet on the 19th floor of a building 2 blocks from our main computer storage area. There are firewalls and cement construction in this building, and the storage cabinet is in a closed room. The only access to this information is four authorized VAMC-CIM individuals. However, to further protect our media, we have been discussing as a result of 911 events the possibility of purchasing a specific media storage safe, which provides adequate fire, water, and climate controls, as well as access security. The upgraded media storage cabinet is scheduled for installation by January 15, 2003.

- **Quarterly reviews of the continued need for remote access had not been performed, and documentation granting remote access had not been maintained.**

A Remote Access System report was ran on November 21, 2002. A list of users was sent to each Service Line, asking for justification for each user in their section. After receiving justification, a report was compiled and the report was given to the IG Reviewer on November 22, 2003.

- **Equipment disposal procedures did not assign responsibility and appoint an official to certify that sensitive information has been removed before disposal.**

Clinical Information Management has a procedure, Procedures for Safeguarding Sensitive Information Stored on Automatic Data Processing Equipment During Disposal, in place to address removal and disposal of sensitive information from computer hardware. The designated official is the facility Information Security Officer. This responsible individual is cited in the attachment of the Automated Information System Facility Policy 00-20.

- **Signage denoting communication closets was not appropriate.**

The VAMC New Orleans has 42 communications closets. 21 of the closets have no signage, 7 closets have a communication closet sign, and the remainder has simply the room number. All closets with communication closet signs have been changed to reflect just the room number. The 21 closets without signs now have room numbers added to them.

- **Destruction of Sensitive Info on PCs.**

VAMC New Orleans currently has a procedure in place wherein the Supervisor of the PC/Repair Section is responsible for ensuring that PC technicians appropriately destroy disk drives in equipment to be excessed. He ensures that each technician certifies drives were destroyed, attach a copy of the certification form to the PC prior to excess, and these are verified to be attached to each PC prior to Materials Management picking up. Our procedure has been incorporated into a written policy expressly designating the Supervisor PC Team as the responsible individual for ensure proper destruction of sensitive information.

Inspection and Disposition of Controlled Substances

- **Pharmacy is not conducting 72-hour bulk inventories.**

Pharmacy Management reviewed narcotic 72-hour bulk inventory records. The records indicate that the Narcotic Pharmacist inspected the bulk inventory at least weekly during FY 2002 and at least 72 hours during last two months during that fiscal year. Pharmacy Management has an internal procedure: Ordering and Receiving Controlled Substances to guide the Narcotic Pharmacists in the time frame for conducting bulk inventories. Pharmacy Administration will monitor the 72-hour inventory on a monthly basis. This will be done in addition to the Controlled Substance Inspection Procedure conducted by the Chief of Staff's office. The Narcotic Pharmacist will track the inventory monthly by separately filing each form 10-2320 by name of the bulk narcotic. There is also a contingency plan in which the Outpatient Pharmacy Supervisor counts the narcotic during holidays and weekends to ensure the 72-hour time frame.

- **There are no motion detectors in the Outpatient Pharmacy.**

Pharmacy Management reviewed the IG recommendations. There are two motion detectors in Outpatient Pharmacy that were disconnected during the recent renovation of Outpatient Pharmacy. Biomedical Department reactivated both motion detectors on 11/27/02.

- **The Assistant Chief of Pharmacy was not aware of the DEA requirement to report narcotic theft to the DEA.**

The VHA Handbook 1108.2 has been reviewed with Pharmacy management and staff with an emphasis on the requirement to report all narcotic thefts to DEA. Staff has been informed of a procedure to report alleged narcotic thefts to facility police, MC Director and the DEA.

- **Expired or unusable narcotics awaiting disposal are not inspected during monthly inspections.**

VAMC New Orleans has a procedure in place that assures the inspection of expired or unusable narcotics. The Medical Center has a Controlled Substance Inspection Procedure. The monthly

inspection performed by the Chief of Staff's office consists of a complete drug count including expired or unusable narcotics awaiting disposal.

- **Narcotics awaiting disposal are not separated in containers for inspection.**

VAMC New Orleans has a procedure, Prime Vendor Purchasing for separating narcotic awaiting disposal. The Narcotic Pharmacist collects and holds excess or expired narcotics in the Outpatient pharmacy vault for return to the vendor. The pharmacist place narcotics awaiting disposal in a separate container with computer print outs of name of the expired drugs attached to the outside of the container.

Contract Award and Administration

- **One non-competitive contract could have had price negotiations.**

Documentation training for procurements is being presented to Contract Specialists and Purchasing Agents. Completion was accomplished on December 12, 2002.

Additionally, the section supervisor will be performing additional random audits of the files. This is in addition to the performance reviews already being done against Performance Standards for employees with results documented in the performance appraisal.

- **The medical center overpaid a contractor for repairs to equipment. The COTR did not verify that the rates for the repairs were contracted rates.**

The vendor did a preliminary review and issued a letter which acknowledged their pricing was inaccurate and will work with the VAMC New Orleans to identify all invoices paid. Once found we will calculate the reimbursement. A review of the COTR Delegation of Authority memorandum issued with every contract to ensure that the verification of pricing is covered, has been completed. Specific training reviews with COTR for all contracts are scheduled to be completed by January 10, 2003.

Government Purchase Card Program

- **The purchase card program is underutilized: Contracting Officers don't have purchase cards and Purchasing Agents card limits are set too low.**

The term Contracting Officers is not accurate. The Surveyor was referring to the Contract Specialists who prepared contracts exceeding $100,000 for categories of Construction, Services, Supplies, Scarce Medical Specialists, Leases, etc. The surveyor believed all obligation contracts (which are not all categories identified) should be completed with the Purchase Card if vendor accepts VISA. A quick review of construction contracts for the large contracts prepared by the Contract Specialists indicated that they do not accept the VISA Purchase Card. The Purchasing Agents have Basic Warrants up to $100,000 and we have increased their limits.

The Purchasing Agents limits have been raised. However, for the Contract Specialists we have to request new Purchase Cards, provide training, establish the menus and prepare new warrants, which will take 30 days. This is scheduled to be completed by January 6, 2003.

- **Purchases are split to stay within spending limits.**

The annual Purchase Card training is scheduled for January 2003 and will cover this issue with the cardholders and their approving officials. In addition, the joint Fiscal and MMSL quarterly audits will specifically search for split orders and document the findings.

- **Quarterly audits or cardholder accounts are not being conducted.**

Audits were conducted by Fiscal but did not include MMSL as required by the updated handbook. A joint Fiscal/MMSL audit of all cardholders has begun with 1st quarter FY 2003.

- **Annual Quality Assurance Reviews are not performed.**

Internal audits (Quality Assurance Reviews) have begun. Three of the six have been completed. All will be completed by January 10, 2003.

CBOC Operations

- **Pharmacy disposal of controlled substances was not timely.**

Expired controlled substances at the Baton Rouge Outpatient Clinic pharmacy are now disposed on an annual bases. Disposals may occur more frequently if necessary. The disposal process will be monitored by the General Supply Specialist. Destruction of narcotics is accomplished through a private vendor in accordance with all regulations.

- **MCCF is out of balance. This appears to be a nation-wide problem with the system.**

While this is a VA nation wide problem, we will continue to monitor the problem by working with individual veterans as the problems are brought to our attention. As soon as a national patch is released correcting the problem, it will be installed.

Research Security

- **Housekeepers clean sensitive research laboratory areas after hours.**

Cleaning schedules for Research laboratories have been modified to provide services when Research staff is in the area.

Management of Violent Patients

- **Only 4 of 10 patients involved in incidences of violent behavior had notes recording those events in CPRS. Only one of the 10 patients had a clinical warning in CPRS**.

Numbered Memorandum 00-15, Management of disruptive, threatening or Violent Behavior, has been amended to state that the Patient Safety Manager will enter a description of the event into CPRS.

- **Flags are not used in the VISTA system.**

Flags now appear in both CPRS and VISTA. Numbered Memorandum 00-15, Management of Disruptive, Threatening or Violent Behavior has been amended.

- **There is no tracking of completion of safety/vulnerability deficiencies.**

There is a VISN wide initiative underway to better and more uniformly report and track completion of safety/vulnerability deficiencies. Until this VISN policy is adopted the results of all safety/vulnerability assessments will tracked by the Office of the Chief of Staff.

- **The Disruptive, Threatening, Violent Behavior Team reviews, evaluates, and makes recommendations on Uniform Offense Reports only. Patient incident reports are not forwarded for review.**

Staff has been reminded, via outlook e-mail message, to report all incidents of disruptive, threatening or violent behavior on VA Form 10-2633, Report of Special Incident Involving a Beneficiary. Numbered Memorandum 00-15, Management of Disruptive, Threatening or Violent Behavior, has been amended to reflect this aspect of the reporting process.

- **Only one alert flag was placed in CPRS during the previous fiscal year.**

All records of the patients involved in incidences of disruptive, threatening or violent behavior identified in the OIG review have been reviewed to determine if a CPRS clinical warning is indicated. Following the review, it was determined that two of these records warranted a flag. Those records have been flagged. The clinical parameters of the remaining records excluded justification for a flag.

Environment of Care

- **Canteen dining room needed improved maintenance and cleaning.**

Daily cleaning of the Canteen dining room is performed by both housekeeping staff and volunteers. Dining room floor was recently stripped and waxed. In addition to rounds performed by Safety and Infection Control staff, the Associate Director conducts weekly environmental rounds in the Canteen. The entire dining area is scheduled for renovation in January 2003. Maintenance items mentioned during the survey have been completed.

- **Canteen kitchen, storage room, and employee locker rooms needed repair and cleaning.**

A cleaning agreement (written service contract) exists between Canteen and Environmental Management (housekeeping) to ensure areas of responsibilities are performed through a routine cleaning schedule. In addition to rounds performed by Safety and Infection Control staff, the Associate Director conducts weekly environmental rounds in the Canteen. Maintenance items mentioned during the survey have been completed.

- **There were 2 outdated crash carts in the outpatient clinics (Pulmonary and Urgent Care).**

The Crash Cart check procedure has been changed to include the recording of the actual expiration date on the daily cart check sheet.

- **Patient bathrooms on 8C needed deep cleaning.**

Patient bathrooms on 8C experience high use and are often in need of more frequent cleaning due to the Mental Health patients that utilize the area. The bathrooms have been deep cleaned.

- **Laundry bag racks were broken.**

Rack repair has been completed.

Appendix B

VISN 16 Director Comments

Department of Veterans Affairs

Memorandum

Date: March 14, 2003

From: Network Director (10N16), South Central VA Health Care Network (SCVAHCN)

Subj: OIG Combined Assessment Draft Report (CAP), VAMC, New Orleans, LA (Project No. 2003-03264-HI-0385), Facility Responses to Recommendations

To: Office of Inspector General (53B)
Thru: Management Review and Administration (105E)

1. The SCVAHCN 16 has reviewed the response from the VA Medical Center, New Orleans, Louisiana, regarding the subject CAP Report and concur with their responses.

2. If you have questions or need additional information, please contact Mr. John Church, Center Director, VAMC, New Orleans, at 504.589.5980.

/signed/
Robert Lynch, M.D.

Attachment

Appendix C

VA Medical Center Director Comments

We appreciate the review including three organizational strengths of which we are also proud. The Medical Center was asked to only comment on the recommended improvement actions. That has been done.

Responses: Opportunities for Improvement

Government Purchase Card Program

Recommended Improvement Action 1.

a. Purchase card limits for purchasing agents are increased as appropriate. **Concur**
The Purchasing Agents limits have been raised to an appropriate level.

b. Purchase cards with appropriate single purchase limits are issued to contracting officers. **Concur**
New cards were received and distributed to Purchase Card Holders in the middle of February 2003 for Contracting Officers to use for single purchase limits.

c. Purchase cards are used to purchase equipment and services that exceed $10,000. **Concur**
During February 2003, all cardholders were trained to use purchase cards on all purchases of equipment and services that exceed $10,000. Purchase cards are now being used to purchase equipment and services that exceed $10,000.

d. Cardholders complete the required certifications during the reconciliation of purchase card transactions, and approving officials approve reconciled transactions more timely. **Concur**
Refresher training conducted with all cardholders during audits. Both Materials Management and Fiscal Service monitor reports continuously. Recent reports for New Orleans in FY-03 showed compliance with regulations.

e. Quarterly audits are conducted of all purchase cardholder accounts not reviewed during the monthly audits conducted by the VA FSC. **Concur**
Audits for FY-03 2nd quarter were conducted in February 2003. A quarterly schedule has been established for consistency in the future.

Automated Information Systems

Recommended Improvement Action 2.

a. Major AIS are certified. **Concur**

A new procedure is in place that has the Medical Center Director and the systems managers certifying all risk assessments and contingency plans shown on the Authorization to Process.

b. Contingency Plans include all of the appropriate elements. **Concur**
AIS Security plans have been reviewed to include all appropriate elements and will be updated on an as needed basis.

c. Continued need for remote access is reviewed quarterly. **Concur**
The first quarter FY 2003 quarterly review has been completed. This review will be done during the last week of each quarter.

d. AIS back-up tapes are stored in a fireproof safe with limited access. **Concur**
A storage safe providing adequate media protection has been purchased and will be installed in the offsite area (safe was damaged in shipment and is awaiting repair prior to install) Completion date: 4/30/03.

e. An official is designated, in writing, to certify that AIS equipment is cleared of sensitive information. **Concur**
The Information Security Officer is designated in Numbered Memorandum 00-20 effective 3/17/03.

f. Signs identifying the location of closets containing AIS telecommunications equipment are removed. **Concur**
All closets with communications closet sign have been changed to reflect just the room number. The 21 closets without signs now have room numbers added to them.

Management of Violent Patients

Recommended Improvement Action 3.

a. Require that all incidents of patient violence be forwarded to the DTVB for evaluation and appropriate action. **Concur**
Staff has been reminded, via Outlook email message, to report all incidents of disruptive, threatening or violent behavior on VA Form 10-2633, Report of Special Incident Involving a Beneficiary. Numbered Memorandum OO-15, Management of Disruptive, Threatening, or Violent Behavior has been amended to reflect this aspect of the reporting process. All incidents of patient violence are now reported to the DTVB team by either the Patient Safety Manager or through police reports.

b. Develop a process to place computerized flags into VISTA and CPRS simultaneously. **Concur**
Flags now appear in both CPRS and VISTA for the alert to be viewed in each system. Numbered Memorandum OO-15, Disruptive, Threatening, or Violent Behavior has been amended to reflect the change.

c. Establish procedures to assure the implementation of recommendations that result from the annual safety and vulnerability assessment. **Concur**

Annual physical security surveys are now completed of all areas then forwarded to Service Line Directors and Corporate Function Managers for concurrence/action on any deficiencies found. Police Service follows up on actions on appropriate basis until abatement of deficiencies is accomplished.

Research Laboratory

Recommended Improvement Action 4. Ensure that the Medical Center Director require that access for routine cleaning of the Research Service laboratories be limited to hours when research employees are present. **Concur**

Cleaning schedules for research laboratories have been modified to provide services only when research staff is in the area.

Contract Award and Administration

Recommended Improvement Action 5.

a. All bills for the PAC System maintenance and repair contract are reviewed and overcharges are collected from the contractor. **Concur**

Pricing overcharges were identified. Employees have been instructed to carefully review all charges before payment is made to ensure accuracy. This contractor has been put on notice that his charges were incorrect and are being closely monitored. The contractor will apply a credit to the next bill.

b. COTR's verify contractor bills to ensure that the rates billed are consistent with contract rates. **Concur**

Delegations of Authority in each service contract were re-issued with specific language concerning the responsibility for verification of contractor bills. Delegations have been signed and are on file. Audits by Fiscal Service and through the Purchase Card Program will monitor compliance.

Controlled Substances Security

Recommended Improvement Action 6.

a. Inventories of controlled substances are verified every 72 hours. **Concur**

As of November 2002, inventories of controlled substances are conducted and verified every 72 hours on a consistent basis.

b. Receiving reports are compared with Pharmacy Service controlled substances inventory records during monthly, unannounced controlled substances inspections. **Concur**

A tool has been developed to document the comparison of receiving reports with the Pharmacy Service controlled substance inventory reports. The tool was

finalized in March 2003 and will be utilized along with monthly inspections beginning the first 2 weeks in April. The completed tool will be held as a permanent part of the monthly inspection record.

c. Expired or unusable controlled substances are disposed of quarterly. **Concur**

Expired or unusable controlled substances are now disposed of at least quarterly at the Medical Center and the Baton Rouge Outpatient Clinic. Both facilities have a set schedule for the contracted vendor to pick up expired or unusable controlled substances.

d. A local sounding alarm is installed on the intrusion detector in the outpatient pharmacy. **Concur**

Installation of a local alarm system is in progress and will be completed by March 18, 2003.

Environment of Care

Suggested Improvement Action. We suggest the VISN Director ensure that the Medical Center Director take action to correct these deficiencies. **Concur**

All deficiencies from the Environment of Care Section have been addressed.

VCS Environment:

It should be noted that there is a defined distinction between items identified as safety and infection control issues and those identified as aesthetic conditions. We have a funded renovation project for the canteen that will improve aesthetic conditions.

- Dirty tabletops and torn cushions in the seating units of the dining room.

  We have a staff of volunteers and employees who have been instructed to maintain the dining room. At any given moment there will be some tables in need of cleaning; they are cleaned throughout the day. The seat cushions on some units are torn. They are scheduled to be removed during the project. New furniture will be installed.

- Grime and debris on floor edges in the food preparation area, dining room, storage room, around furniture in the dining room and shelving in the storage room.

  All these areas have been cleaned. This is now checked and maintained daily.

- A dirty film on all walls, and dirt accumulation in the grout in the employee locker rooms.

  Area cleaned. Checked and maintained daily.

- Malfunctioning toilet in the female employees locker room.

  Toilet was repaired. All employees instructed to report damaged, broken, or malfunctioning equipment immediately to a supervisor.

Monetary Benefits in Accordance with IG Act Amendments

Report Title: Combined Assessment Program Review of the VA Medical Center, New Orleans, Louisiana

Report Number: 02-03264-148

Recommendation	Explanation of Benefit[s]	Better Use of Funds
1(a)-(c)	Improved utilization of Government purchase cards could result in additional rebates.	$630,000
5(a)	Verification of rates billed for contracted services will ensure that contractors are not overpaid for services.	1,295
	Total	$631,295

Appendix E

Distribution

VA Distribution

Secretary (00)
Deputy Secretary (001)
Chief of Staff (00A)
Deputy Chief of Staff (00A1)
Executive Secretariat (001B)
Under Secretary for Health (105E)
Chief of Staff to the Under Secretary for Health (10B)
Deputy Under Secretary for Health for Operations and Management (10N)
Director, Veterans Integrated Service Network (10N16)
Director, Center for Patient Safety (10X)
Assistant Secretary for Public and Intergovernmental Affairs (002)
Assistant Secretary for Management (004)
Assistant Secretary for Information and Technology (005)
Assistant Secretary for Human Resources and Administration (006)
Assistant Secretary for Policy and Planning (008)
General Counsel (02)
Deputy Assistant Secretary for Congressional Affairs (009C)
Deputy Assistant Secretary for Acquisition and Materiel Management (049)
Director, Management and Financial Reports Service (047GB2)
VHA Chief Information Officer (19)
Deputy Assistant Secretary for Public Affairs (80)
Medical Inspector (10MI)
Director, VA Medical Center, New Orleans, LA (629/00)

Non-VA Distribution

Office of Management and Budget
U.S. General Accounting Office
Senator John Breaux
Senator Mary Landrieu
Congressman William Jefferson
Congressional Committees (Chairmen and Ranking Members):
- Committee on Governmental Affairs, U.S. Senate
- Committee on Veterans' Affairs, U.S. Senate
- Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. Senate
- Committee on Veterans' Affairs, U.S. House of Representatives
- Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives
- Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of Representatives
- Subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, U.S. House of Representatives

Appendix E

Subcommittee on National Security, Emerging Threats, and International Relations, Committee on Government Reform, U.S. House of Representatives
Staff Director, Committee on Veterans' Affairs, U.S. House of Representatives
Staff Director, Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs, U.S. House of Representatives

This report will be available in the future on the VA Office of Inspector General Web site at http://www.va.gov/oig/52/reports/mainlist.htm, *List of Available Reports*. This report will remain on the OIG Web site for 2 fiscal years after it is issued.