Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Gulf Coast Health Care System Biloxi, Mississippi

Report No. 04-01946-188

August 27, 2004

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

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

To Report Suspected Wrongdoing in VA Programs and Operations

Call the OIG Hotline – (800) 488-8244

Contents

Executive Summary

Introduction

During the week of June 14-18, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Gulf Coast Veterans Health Care System, Biloxi, Mississippi. The purpose of the review was to evaluate selected 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 316 employees. The System is under the jurisdiction of Veterans Integrated Service Network (VISN) 16.

Results of Review

This CAP review focused on 12 areas. As indicated below, there were no concerns identified in seven of the areas:

- Contract Award and Administration
- Government Purchase Card Program
- Inventory Management
- Moderate Sedation
- Patient Care Administration
- Follow Up to Previous CAP Recommendations
- QM

Reviews of the remaining five areas resulted in recommendations for improvement:

- Develop a comprehensive facility policy governing the Bulk Oxygen Utility program.
- Improve Automated Information System (AIS) Security.
- Improve surveillance on the locked psychiatry unit.
- Improve inventory management and monthly inspections of controlled substances.
- Correct patient safety and cleanliness issues.

This report was prepared under the direction of Ms. Victoria Coates, Director, Atlanta Regional Office of Healthcare Inspections, and Ms. Bertie Clarke, CAP Team Leader, Atlanta Regional Office of Healthcare Inspections.

VISN 16 and System Directors' Comments

The VISN and System Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See pages 12-23 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

Facility Profile

Organization. The VA Gulf Coast Health Care System (the System) located in Biloxi and Gulfport, MS, provides tertiary care and a broad range of inpatient and outpatient health care services. Outpatient care is also provided at three community-based outpatient clinics located in Pensacola and Panama City, Florida and Mobile, Alabama. The System is part of VISN 16 and serves a veteran population of 227,772 in a primary service area that includes 18 counties in Alabama, Mississippi, and Florida.

Programs. The System provides medical, surgical, mental health, geriatric, and rehabilitation services. The System has 214 hospital beds, 160 nursing home beds, and 171 domiciliary beds. The System operates several regional referral and treatment programs and has sharing agreements with Keesler Air Force Base (AFB), Eglin AFB, Tyndall AFB, the Navy Hospital in Pensacola, Florida, and five community hospitals.

Affiliations and Research. The System is affiliated with the University of South Alabama College of Medicine and Tulane University and supports 27 medical resident positions in 10 training programs. In Fiscal Year (FY) 2003, the System had 23 research projects with a budget totaling $251,142. Important areas of research include smoking cessation, trauma-specific guided imagery, diabetes, hypertension, and hyperlipidemia.

Resources. In FY 2003, medical care expenditures totaled $150 million. The FY 2004 medical care budget is $178 million. FY 2003 staffing totaled 1,619 full-time equivalent (FTE) employees, including 162 physician and 480 nursing FTE.

Workload. In FY 2003, the System treated 47,182 unique patients. The System provided 45,986 inpatient days of care in the hospital, 55,266 inpatient days of care in the Nursing Home Care Unit (NHCU), and 53,922 inpatient days of care in the domiciliary. The inpatient care workload totaled 4,195 discharges, and the average daily census, including nursing home patients, was 425. The outpatient workload was 467,977.

Objectives and Scope of the CAP Review

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

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, quality management, benefits, and financial and administrative controls.

- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity 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. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. The review covered facility operations from March 2002 through June 15, 2004, and was done in accordance with OIG standard operating procedures for CAP reviews.

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:

AIS Security	Inventory Management
Bulk Oxygen Utility System	Moderate Sedation
Contract Award and Administration	Follow Up to Previous CAP Recommendations
Controlled Substances Accountability	QM
Environment of Care	Locked Psychiatric Unit Surveillance
Government Purchase Card 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 1,619 employees, 218 (13 percent) of whom responded. We also interviewed 38 patients during our site review. We provided the full survey results to facility managers.

During the review, we also presented four fraud and integrity awareness briefings and 316 facility employees attended, either in person, or by video conferencing. The briefings 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.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented.

Follow Up to Previous CAP Recommendations

As part of this review, we followed up on the recommendations and suggestions resulting from a prior CAP review of the facility *(Combined Assessment Program Review of the VA Gulf Coast Veterans Health Care System, Report No. 00-0933-88, June 19, 2000)*. In January 2000, the OIG found a health care system where top managers and a core group of physicians could not effectively collaborate on behalf of patients. In June 2004, we found an improvement in the professional environment. System managers adequately addressed recommendations made in the prior CAP report, and the previously cited conditions were corrected.

Results of Review

Organizational Strengths

System management has taken effective steps to improve professional interaction and cooperation, and to eliminate conditions that inhibit effective delivery of patient care. Communication is a critical component in the effective delivery of healthcare. System management, service chiefs, and supervisors from all clinic and program sites, including CBOCs, now participate in daily morning meetings to ensure that important clinical and administrative areas are operating effectively. Managers and supervisors report on issues including staffing, workload, no-shows, timeliness, accessibility, and adverse events. QM staff maintain a record of each day's reports, and track issues requiring follow-up and resolution. Through these meetings, top management learns about problems in a timely manner, allowing them to take immediate corrective action. In addition, managers and supervisors learn about operations and potential problems in other System departments that could affect the provision of services in their areas.

The System has shown improved performance in several areas since management began the daily meetings, and managers are publicly accountable for performance in their divisions or clinics. One example of improvement that could be attributed, at least in part, to improved communication and accountability relates to clinic cycle times. For the period March 2003 through June 2004, the percentage of patients seen within 20 minutes of their scheduled appointment times (all clinics) increased from an average of 65 percent to an average of 81 percent.

Opportunities for Improvement

Bulk Oxygen Utility System – Oversight Needed Strengthening

Condition Needing Improvement. The bulk oxygen main panel alarms were disconnected from the oxygen tanks for a period of at least 20 months. Annual inspections by the vendor in July 2002 and September 2003 revealed that the bulk oxygen system main panel alarms, located in the boiler room and the emergency room, were not functional as required by the National Fire Protection Association standard on alarm systems used for medical gas systems (NFPA 99 - 5.1.9). Engineering employees acknowledged receipt of the Customer Inspection Certificate and signed both inspection reports, which documented that the alarms were not connected.

We found no evidence that Engineering employees either reported or attempted to correct this condition following the July 2002 inspection. Two weeks after the September 2003 inspection, Engineering employees initiated a low-priority work order. Main panel alarms were not functional again until April 21, 2004, after a VHA Patient Safety Alert was issued.

In addition, we found that:

- Engineering employees did not present the issue of the non-functioning alarms to the Safety Committee.
- Engineering employees had not yet corrected back-up oxygen alarm deficiencies identified in the April 12, 2004 Medical Gases Inspection report.
- Supply, Processing, and Distribution (SPD) employees did not consistently check the oxygen gauges weekly.
- SPD employees did not supervise the delivery of the oxygen by the vendor.

These conditions resulted, in part, because management of the bulk oxygen utility system was fragmented. Responsibility crossed service lines and none of the involved services had ownership of the process. Acquisition and Materiel Management Service (A&MMS) contracted with the vendor providing the oxygen and SPD had responsibility for monitoring the oxygen pressure and level gauges on the main and reserve oxygen tanks. The Engineering section of Facilities Management Service had responsibility for monitoring the alarm system, although the vendor conducted the actual alarm tests.

Without a coordinated Bulk Oxygen Utility System program, managers could not ensure a safe, secure, and available bulk oxygen supply.

Recommended Improvement Action(s) 1. The VISN Director should require the System Director to develop a comprehensive facility policy governing the Bulk Oxygen Utility program. This policy should assign primary responsibility to a single system

manager, and should delineate requirements regarding the supervision of oxygen delivery, gauge monitoring, alarm testing, employee training, and mock drills for loss of oxygen emergencies. The policy should also require that inspection results be forwarded to the Safety Committee.

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

AIS – Security Needed Improvement

Condition Needing Improvement. The following AIS security conditions required management attention:

- The System's contingency plans were not comprehensive.
- Contingency plan tests were not documented.
- An appropriate alternate processing and storage site had not been identified.
- Background investigations had not been requested for key System staff and contractors.
- User access and privileges were not reviewed in a timely manner.
- Not all System staff were provided AIS security training.

Contingency Plans. Contingency plans for the Veterans Health Information Systems and Technology Architecture (VISTA), Local Area Network (LAN), Microsoft Exchange, and Picture Archiving and Communication System were not comprehensive and lacked key elements required by VA Handbook 6210, such as:

- Critical functions and resources needed in the event of an emergency.
- After hour telephone numbers for key personnel, including the Director; Chief of Staff; Information Security Officer (ISO); Alternate ISO; Chief, Engineering Service; Chief, Bio-Medical Engineering Service; and the Safety Officer.
- Identification of the members of the disaster recovery team and the specified roles they would perform in the disaster recovery process.

Contingency Plans Testing. The Chief Information Officer (CIO) told us that the contingency plans were tested annually, but they did not maintain test documentation. Lack of documentation inhibits management's ability to correct problems. VHA policy requires that annual contingency plan testing be documented.

Alternate Processing Site. The System's contingency plan identified the alternate processing and back-up storage site as an alternate computer room located in a building adjacent to the main computer room. VHA policy requires that the alternate processing

site be in a location that would not be affected by the same disaster. According to the CIO, they would arrange to use VA Medical Center Jackson as the alternate processing and back-up storage site.

Background Investigations. Background investigations for key System staff and contractor employees were not requested in a timely manner. VA policy requires that investigations be requested before individuals are granted access to sensitive system data. Background investigations for the ISO, the Chief, Information Resource Management, and two Information Technology specialists were not requested until more than one year after they were assigned to their positions. In addition, 54 of 58 (93 percent) contractor employees had access to sensitive system data without having background investigations.

User Access and Privileges Reviews. Quarterly user access and privileges reviews of the LAN and Microsoft Exchange were not conducted. The ISO also did not properly perform quarterly user access and privileges reviews of the continued need for VISTA access. As of May 6, 2004, the System had 783 VISTA accounts for individuals who were not System employees. We found 26 VISTA accounts that had not been accessed in over 90 days, and we determined the following:

- 5 VISTA accounts had never been accessed and were terminated after May 6, 2004.
- 9 VISTA accounts had been accessed after May 6, 2004, and have a continued need to access the system.
- 11 VISTA users no longer required access and the ISO agreed to terminate the accounts.
- 1 VISTA user retired and returned to the System as a contractor requiring access. The ISO stated he would ensure that the individual's access level was appropriately reset.

VISTA user access should be reviewed quarterly to identify and terminate accounts that are not needed.

AIS Security Awareness Training. The System had provided annual security awareness training to only 71 percent of the System staff during Fiscal Year 2003. VHA policy requires that AIS security awareness training be provided to all staff. The ISO should ensure that all System staff participate in annual AIS security awareness training.

Recommended Improvement Action(s) 2. The VISN Director should require that the System Director takes action to ensure that: (a) Contingency plans comply with requirements cited in VA Handbook 6210. (b) Contingency plans are tested annually and the results documented. (c) An appropriate alternate processing and back-up storage site meeting VHA requirements is selected. (d) Appropriate background investigations of AIS users are completed in a timely manner. (e) User access and privileges are reviewed quarterly. (f) All System staff complete annual AIS security awareness training.

The VISN and System Directors agreed with the findings and recommendations, and the VISN Director agreed with the System Director's corrective action plan. The System

Director provided acceptable improvement plans. We will follow up on the planned actions until they are completed.

Locked Psychiatry Unit – Increased Surveillance is Needed

Condition Needing Improvement. Ceiling panels in hallways and visitation room 121 on unit 62 G 1 (locked acute psychiatric unit) did not prevent access to interstitial areas. In addition to increasing suicide risk, contraband could be hidden behind the panels. Some of the hallways and the visitation room were also not observable from the nursing station, yet did not contain video cameras or appropriately placed mirrors to facilitate visualization of these spaces by staff. According to the VA Center for Engineering and Occupational Safety and Health (CEOSH) Guidebook EC 2004, behavioral health facilities "should minimize blind spots in corridors where patients can not be observed from the nurse's station." In a 1998 Sentinel Event Alert, JCAHO reported that 75 percent of suicides in hospital settings were by hanging, and contributing factors included inadequate security and incomplete or infrequent patient observations. We found documentation that this issue had been discussed many times since 1991, but requests to install cameras were denied. During the Patient Safety and Environment of Care Committee meeting of November 25, 2002, it was decided that there was "not enough conclusive justification for a video surveillance system at this time."

The locked psychiatry unit, located at the Gulfport division, is scheduled for relocation to Biloxi in the next few years. However, as long as patients remain on the unit, the condition of reduced visibility in the acute psychiatric unit needs resolution. At a minimum, facility managers should install several strategically placed mirrors to improve patient and employee safety.

Recommended Improvement Action(s) 3. The VISN Director should ensure that the System Director installs mirrors immediately on unit 62 G 1.

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

Controlled Substances Security – Inventory Management and Monthly Inspection Program Needed Improvement

Condition Needing Improvement. The System's controlled substances inventory management and unannounced-monthly inspections program did not meet the requirements of VHA policy.

Inventory Management Needed Improvement. We found that improvements were needed in the use of Pharmaceutical Prime Vendor (PV) inventory management tools,

witnessing of the receipt and posting of controlled substances by an A&MMS Accountable Officer, accuracy of 72-hour controlled substances inventory sheets, and timely destruction of controlled substances.

PV Inventory Management Tool. Pharmaceutical PV inventory management tools were not utilized to monitor stock levels as required by VHA policy. According to the Pharmacy Service procurement officer, only the PV cost analysis report was used to manage inventory. PV reports were not used to monitor utilization or adjust inventory levels, reorder points, or resource objectives. The Chief, Pharmacy Service, stated that the prior Chief had not implemented the PV inventory management tools, as he did not consider it a priority. Additionally, the current Chief was not familiar with the PV's inventory management software applications.

Accountable Officer. A&MMS had not designated an Accountable Officer in writing as required by VHA policy, to witness the receipt and posting of controlled substances. We found that controlled substances were delivered directly to the Pharmacy Service controlled substance vault, and opened and counted by the controlled substances vault pharmacist. Another pharmacist verified the receipt and posting to the pharmacy inventory. VHA Handbook 1108.1 requires that an A&MMS employee witness the receipt and posting of controlled substances.

Controlled Substances 72-Hour Inventory Sheets. Controlled substances 72-hour inventory sheets did not always reflect the number of controlled substances actually counted during the inventories. Discrepancies between the recorded inventory and the 72-hour inventory count were not resolved, and inventory adjustments were not always made prior to the next 72-hour inventory.

Destruction of Controlled Substances. Unusable and expired controlled substances were not destroyed quarterly as required. Unusable and expired controlled substances were only destroyed four times during the last 20 months.

Monthly-Unannounced Controlled Substances Inspections. Controlled substances inspections were not conducted in accordance with VHA policy. Some inspectors did not:

- Check for expired controlled substances.
- Count controlled substances in open containers.
- Check the destruction log for previously destroyed controlled substances.
- Enter the actual controlled substances inventory count on the inventory sheets.

In addition, one controlled substances inspector conducted 10 consecutive inspections of the same area. VHA policy states that an inspector should not inspect the same area more than two consecutive times.

The Controlled Substances Coordinator (CSC) needs to ensure that inspectors are properly trained and the CSC should monitor the performance of inspectors by periodically observing monthly-unannounced inspections. During our review, the Chief, Pharmacy Service, and the CSC took prompt action to correct several of the identified deficiencies.

Recommended Improvement Action(s) 4. The VISN Director should require that the System Director takes action to ensure that: (a) The Pharmaceutical PV Inventory Management software applications are implemented to monitor stock levels. (b) A&MMS designates, in writing, an A&MMS employee as the Accountable Officer. (c) Discrepancies found during the 72-hour inventories are resolved and inventory levels are adjusted. (d) Destruction of unusable and expired controlled substances is performed quarterly. (e) Controlled substances inspectors are properly trained. (f) The CSC monitors the performance of inspectors by periodically observing monthly-unannounced inspections.

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

Environment of Care – Improvements Were Needed

Condition Needing Improvement. Some patient care areas needed attention or cleaning. We inspected 21 patient care areas at the Biloxi and Gulfport divisions. We found that the facilities were generally well maintained. However, some issues needed management attention:

- Stock medications were improperly stored in an unlocked cabinet in the Intensive Care Unit (ICU).
- Open drawers of supplies in rusted wire racks and a corroded faucet were noted in the modular unit in the ICU.
- Outdated supplies were found in storage rooms and on carts on the ICU, Ambulatory Surgery Observation Unit (ASOU), and the Specialty Clinic.
- Thermometers were not installed in medication refrigerators.
- Medication refrigerator temperatures were not checked for six consecutive days on one unit.
- Crash cart locations did not have signage in 62 G-1, the Domiciliary, and Building 2.
- The crash cart in the Domiciliary was not checked on weekends.
- Wheel chairs blocked the ASOU fire exit.
- Buckets of cleaning water obstructed dining room doorways in Building 2.

- Some general use bathrooms needed cleaning in Building 1.

Environmental Management Service and Engineering Service managers resolved many of the conditions while the OIG was on site.

Recommended Improvement Action(s) 5. The VISN Director should assure that the System Director takes action to ensure that: (a) Medications and supplies are stored properly. (b) The modular unit used for storage of supplies and medications in the ICU is replaced. (c) Medication refrigerator thermometers are installed and refrigerator temperatures are monitored. (d) All crash cart locations are appropriately marked and crash carts are checked per policy in all patient care areas. (e) Fire exits are not obstructed, and patient pathways remain hazard free.

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

Appendix A

VISN 16 Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 12, 2004

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

Subject: **Combined Assessment Program Review of the VA Gulf Coast Veterans Health Care System, Biloxi, MS, Project Number 2004-01946-HI-0246**

To: Victoria Coates

1. Network 16 concurs with the attached response to the recommendations for improvement generated from the OIG Combined Assessment Program review at the VA Gulf Coast Veterans Health Care System on June 14-17, 2004.

2. Any questions can be addressed to Mary Jones at 601-364-7871.

(original signed by:)

Robert E. Lynch

Appendix B

System Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 11, 2004

From: Director, VA Gulf Coast Health Care System (520/00)

Subject: **Combined Assessment Program Review of the VA Gulf Coast Veterans Health Care System, Biloxi, MS, Project Number 2004-01946-HI-0246**

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

1. Attached is the response to the recommendations for improvement generated from the OIG Combined Assessment Program review at the VA Gulf Coast Veterans Health Care System on June 14-17, 2004.

2. Any questions can be addressed to Linda Morton, Chief, Quality & Performance Management Service, at 228-523-5742.

(original signed by:)

Julie A. Catellier

Appendix B

System Director Comments

System Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General Report:

OIG Recommendation(s)

Recommended Improvement Action(s) 1. The VISN Director should require the System Director to develop a comprehensive facility policy governing the Bulk Oxygen Utility program. This policy should assign primary responsibility to a single system manager, and should delineate requirements regarding the supervision of oxygen delivery, gauge monitoring, alarm testing, employee training, and mock drills for loss of oxygen emergencies. The policy should also require that inspection results be forwarded to the Safety Committee.

(a) A policy for Management of Medical Oxygen Systems (Bulk Oxygen) is developed which centralizes overall accountability for the program to the Chief, A&MM and outlines responsibilities of other disciplines. The accountable manager took responsibility for the program as of June 17, 2004.

Concur **Completion Date: August 5, 2004**

(b) Facility response to the Patient Safety Alert regarding Oxygen Utility Systems is also of note. These activities show that management was acting on the Oxygen Utility Systems prior to the OIG review.

Appendix B

System Director Comments

The alert was received on April 7, 2004. VISN 16 sent an action item on that date requiring documentation of actions to address Oxygen Utility System safety. VA Gulf Coast compiled a report of the actions taken as a result of the safety alert and a report was submitted to VISN 16 on April 26, 2004.

Completion Date: April 26, 2004

(c) VISN assessed the corrective actions on May 6, 2004. A memo was sent to VA Gulf Coast requiring validation of two actions to be completed. These were (1) Validate that monitoring of the Emergency Room and Boiler Room alarms is occurring, and (2) Ensure an adequate supply of portable oxygen with an appropriate mixture of tanks is available for deployment at point of health care delivery in the event of total Oxygen Utility System failure.

Completion Date: May 14, 2004

(d) Immediately after the OIG review was completed, the Director enhanced the safety alert reporting process. Safety alerts are reported to the Director within 24 hours, or immediately if they are high risk. These alerts are reported at morning report and the status is tracked until completion.

Completion Date: June 18, 2004

(e) Immediately after the OIG review, the Compliance Officer conducted a focused review of Oxygen Utility. All historic records, policies and procedures were reviewed. Recommendations were made to improve the monitoring process and for results to be reported to the Patient Safety and Environment of Care Committee, which is chaired by the Associate Director.

Completion Date: July 7, 2004

Appendix B

System Director Comments

(f) Immediately after the OIG review, and prior to completion of the Management of Medical Oxygen Systems policy, the Bulk Oxygen Safety Monitoring Program was revised to include specific service responsibilities, monitors, frequency and an overall flowchart for the process. It includes monitoring of both the alarm panels, as well as the tank. Daily logs are kept of these monitors with oversight by the Safety Officer on a monthly basis.

Completion Date: July 9, 2004

(g) A Root Cause Analysis Team has been chartered to determine causative factors for the findings. The Bulk Oxygen Safety Monitoring Program will be further improved as determined by the RCA. The RCA will also address planned disaster drills for loss of oxygen emergencies.

Completion Date: September 15, 2004

Recommended Improvement Action(s) 2. The VISN Director should require that the System Director takes action to ensure that: (a) Contingency plans comply with requirements cited in VA Handbook 6210. (b) Contingency plans are tested annually and the results documented. (c) An appropriate alternate processing and back-up storage site meeting VHA requirements is selected. (d) Appropriate background investigations of AIS users are completed in a timely manner. (e) User access and privileges are reviewed quarterly. (f) All System staff complete annual AIS security awareness training.

(a) Contingency plans comply with requirements cited in VA Handbook 6210.

The Contingency Plan has been re-written to comply with requirements cited in VA Handbook 6210.

Concur **Completion Date: July 31, 2004**

(b) Contingency plans are tested annually and the results documented.

System Director Comments

SOPs have been developed to meet the requirements cited in VA Handbook 6210. Contingency plans will be tested and documented annually as required beginning September 11, 2004 during the CACHE conversion.

Concur **Completion Date: September 30, 2004**

(c) An appropriate alternate processing and back-up storage site meeting VHA requirements is selected.

A Memorandum of Understanding has been established with Jackson VA agreeing that Jackson is the alternate processing and back-up storage site.

Concur **Completion Date: July 31, 2004**

(d) Appropriate Background Investigations of AIS users are completed in a timely manner.

A process has been initiated to ensure that background investigations are completed in a timely manner. HR includes investigation requirements in each employee recruitment package. Human Resources & Workforce Development Service provides the Information Security Officer with reports of pending investigations, the latest adjudication actions, and results of follow-ups. A summary is reported to leadership on a quarterly basis.

Concur **Completion Date: July 31, 2004**

(e) User Access and privileges are reviewed quarterly.

The ISO requires quarterly menu and key reviews by Service Chiefs. User access and privilege use is reviewed monthly for VISTA and Windows accounts. All accounts are reviewed for necessity at least every 90 days with special focus on contractors and fee providers.

Concur **Completion Date: July 31, 2004**

Appendix B

System Director Comments

(f) All System Staff complete annual AIS security awareness training.

AIS security is considered by leadership to be a condition of employment. A process is in place which requires each employee to complete AIS security awareness training. The ISO provides regular reports to service chiefs and leaders to ensure that all employees are trained. If training is not completed, access is terminated. Disciplinary action is taken for breaches of security.

Recommended Improvement Action(s) 3. The VISN Director should ensure that the System Director installs mirrors immediately on unit 62 G 1.

Concur **Completion Date: July 15, 2004**

Recommended Improvement Action(s) 4. The VISN Director should require that the System Director takes action to ensure that: (a) The Pharmaceutical PV Inventory Management software applications are implemented to monitor stock levels. (b) A&MMS designates, in writing, an A&MMS employee as the Accountable Officer. (c) Discrepancies found during the 72-hour inventories are resolved and inventory levels are adjusted. (d) Destruction of unusable and expired controlled substances is performed quarterly. (e) Controlled substances inspectors are properly trained. (f) The CSC monitors the performance of inspectors by periodically observing monthly-unannounced inspections.

(a) The Pharmaceutical PV Inventory Management software applications are implemented to monitor stock levels.

System Director Comments

Pharmacy Service has fully met local obligations to implement this software. Magnetic barcodes have been affixed to vault shelves where controlled substances are stored. These barcodes also have par levels, which are used to maintain proper ordering. The prime vendor (McKesson) is addressing the problems with the software at the national level. When corrected, local reports will be generated that give historical data of usage of all controlled substances and aid in maintaining proper inventories based on prior usage.

Concur **Completion Date: December 31, 2004**

(b) A&MM designates, in writing, an A&MM employee as the Accountable Officer.

A&MM has assigned accountable officers in writing for all areas that store controlled substances. Signed invoices and documents are maintained.

Concur **Completion Date: July 31, 2004**

(c) Discrepancies found during the 72-hour inventories are resolved and inventory levels are adjusted.

A process is in place to ensure that discrepancies are addressed. All Pharmacy Supervisors have been educated on the proper process of resolving discrepancies and adjusting the inventories, and are aware that all adjustments must be made as soon as the discrepancy is resolved and before the next 72-hour inventory is done. All Pharmacists with vault access have been educated as to the proper procedure for notifying Supervisors of any discrepancies and noting them on the 72-hour inventory sheets along with what actions are being taken to resolve the discrepancy.

Appendix B

System Director Comments

All vault pharmacists have been instructed to call a Supervisor in another area to report any discrepancies and to have the inventory adjusted if their immediate Supervisor is not available. Daily reports of discrepancies at all locations go to the Chief, Pharmacy, Chief, Police & the Associate Director. Daily reports of discrepancies are also reported at morning report to insure leadership awareness. Daily reporting continues until resolution is achieved.

Concur **Completion Date: July 31, 2004**

(d) Destruction of unusable and expired controlled substances is performed

A process is in place to ensure quarterly scheduled destruction of unusable and expired controlled substances. Accountability is assigned to the Biloxi Outpatient Pharmacy Supervisor. This Supervisor is responsible for collecting all unusable and expired controlled substances from all sites and coordinating destruction with A&MM and Police Service quarterly. This supervisor coordinates the destruction with the DEA and follows all guidelines as applicable. Oversight to ensure adherence to the quarterly schedule is provided by the Chief, Pharmacy Service and the Controlled Substances Coordinator. Destructions for FY 2004 have been completed in February and May with another scheduled in August.

Concur **Completion Date: August 31, 2004**

(e) Controlled Substance Security – Inventory management and monthly inspection program.

Appendix B

System Director Comments

The Controlled Substances Program Coordinator initiated a comprehensive training program for all Controlled Substances Inspectors in August 2003. It received high evaluation scores of 4.50 to 4.69 out of a perfect score of 5 because of the program's hands-on approach. Additionally, ongoing one-on-one and computerized training is provided. On April 4, 2004, a VISN 16 clinical review team evaluated the CSITP and cited it as a best practice. The Controlled Substances Program Coordinator meets monthly with the inspectors to ensure that they have a clear working knowledge of their responsibilities as inspectors.

Concur **Completion Date: Training has been in June and July and is ongoing.**

(f) The CSC monitors the performance of inspectors by periodically observing monthly-unannounced inspections.

The Controlled Substances Program Coordinator initiated a system in March 2004 to monitor the inspectors' performance by accompanying them on their unannounced inspections. Since June 18, 2004, over 24 hours of monitoring has documented the effectiveness of the system.

Completion Date: July 31, 2004

Recommended Improvement Action(s) 5. The VISN Director should assure that the System Director takes action to ensure that: (a) Medications and supplies are stored properly. (b) The modular unit used for storage of supplies and medications in the ICU is replaced. (c) Medication refrigerator thermometers are installed and refrigerator temperatures are monitored. (d) All crash cart locations are appropriately marked and crash carts are checked per policy in all patient care areas. (e) Fire exits are not obstructed, and patient pathways remain hazard free.

(a) Medications and supplies are stored properly.

Appendix B

System Director Comments

Stock medications and supplies designated for specific patients are returned to pharmacy or sent with the patient to the receiving unit upon discharge. The Nurse Manager or designee completes a review of current patient medications in the unit daily.

Concur **Completion Date: June 17, 2004**

(b) The modular unit used for storage of supplies and medications in the ICU is replaced.

a. A project management team has been established to plan for renovation of the ICU. An initial meeting with the Chief, FMS and Associate Chief of Staff for Nursing was held on June 25, 2004. Renovation plans include:

i. Medicine cabinet will be removed and replaced with a new sink, small refrigerator, and workspace.

ii. Nurse servers that can be secured will be placed in each patient room.

iii. Nurses' station will be removed and replaced with a smaller nursing workstation allowing for full visibility of all patients within the unit.

Completion Date: December 31, 2004

b. The current medicine cabinet, wire racks and the faucet on this unit have been cleaned. The rust and corrosion has been removed.

Concur **Completion Date: July 14, 2004**

(c) Medication refrigerator thermometers are installed and refrigerator temperatures are monitored.

Medication refrigerator thermometer probes have been properly secured. Staff checks temperatures daily. Nurse managers validate assignment sheets to assure compliance.

Concur **Completion Date: July 31, 2004**

Appendix B

System Director Comments

(d) All crash cart locations are appropriately marked and crash carts are checked per policy in all patient care areas.

New crash cart signage is installed in the Nursing Home Care Unit, Domiciliary, and on Psychiatry. All crash cart locations are properly marked.

Concur **Completion Date: August 10, 2004**

Crash carts are inspected each shift by the Charge Nurse or designee. Nurse Managers monitor the inspection sheets for compliance.

Concur **Completion Date: July 1, 2004**

(e) Fire exits are not obstructed, and patient pathways remain hazard free.

Improperly placed equipment was immediately removed from doorways and stored in a non-traffic area during the CAP inspection. Nurse Managers provide ongoing oversight to ensure patient pathways are clear of obstructions.

Concur **Completion Date: June 17, 2004**

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria H. Coates, Director Atlanta Office of Healthcare Inspections (404) 929-5961
Acknowledgments	James R. Hudson, Director, Atlanta Office of Audit Floyd Dembo, Audit Manager Vivian Branham, Audit Team Leader Bertie Clarke, OHI Team Leader George Boyer Melissa Colyn Harvey Hittner Earl Key Judy Lawhead John McDermott Tina Mitchell Michael Shifrin Christa Sisterhen Sue Zarter

Appendix D

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, South Central VA Health Care Network (10N16)
Director, VA Gulf Coast Health Care System (520/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on VA, HUD, and Independent Agencies
House Committee on Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on HUD-Independent Agencies
Senate Committee on Government Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
Senator John Breaux
Senator Thad Cochran
Senator Bob Graham
Senator Mary Landrieu
Senator Trent Lott
Senator Bill Nelson
Senator Jeff Sessions
Senator Richard Shelby
Congresswoman Jo Bonner
Congressman Allen Boyd
Congressman William J. Jefferson
Congressman Jeff Miller
Congressman Charles W. "Chip" Pickering
Congressman Gene Taylor
Congressman W. J. "Billy" Tauzin
Congressman David Vitter

This report will be available in the near future on the OIG's Web site at http://www.va.gov/oig/52/reports/mainlist.htm. This report will remain on the OIG Web site for at least 2 fiscal years after it is issued.