Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the Carl Vinson VA Medical Center Dublin, Georgia

Report No. 04-03028-49 **December 13, 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.

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Executive Summary

Introduction

During the week of September 20-24, 2004, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the Carl Vinson VA Medical Center, Dublin, Georgia. 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 70 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 7.

Results of Review

This CAP review focused on 12 areas. There were no concerns identified in seven areas:

- Bulk Oxygen Utility System
- Contract Award and Administration
- Emergency Preparedness
- Environment of Care
- Follow Up to Previous CAP Recommendations
- Government Purchase Card Program

Based on our review, the following organizational strength was identified:

- A unique property transfer agreement with the state of Georgia enhanced resources available for patient care and expanded veteran and employee benefits.

Reviews of the remaining five areas resulted in recommendations to improve:

- Moderate sedation documentation.
- QM oversight of committee activities.
- Controlled substances accountability.
- Information technology (IT) security.
- Inventory management practices.

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 and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See pages 13-20 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

Medical Center Profile

Organization. The Carl Vinson VA Medical Center (the medical center) located in Dublin, Georgia, provides a range of inpatient and outpatient health care services. Outpatient care is also provided at two community-based outpatient clinics (CBOCs) located in Macon and Albany, Georgia. The medical center is part of VISN 7 and serves a veteran population of approximately 110,900 in a primary service area that includes 52 counties in middle and south Georgia.

Programs. The medical center has 33 acute hospital beds, 161 nursing home beds, and 145 domiciliary beds. The medical center also has a Memorandum of Understanding with Robins Air Force Base for Tri-Care Mental Health Services.

Affiliations and Research. Although the medical center does not have university affiliations, approximately 45 students from medical schools, universities, or technical colleges perform clinical rotations at the facility each year. The medical center does not have any research projects.

Resources. In fiscal year (FY) 2003, medical care expenditures totaled $69,828,359. The FY 2004 medical care budget is $76,183,365. FY 2004 staffing totaled 753 employees, including 35 physicians and 182 nurses.

Workload. In FY 2003 the medical center treated 24,873 unique patients. The medical center provided 9,048 inpatient days of care in the hospital and 52,794 inpatient days of care in the Nursing Home Care Unit. The inpatient care workload totaled 2,332 discharges, and the average daily census, including nursing home patients, was 169. The outpatient workload was 159,178 visits.

Decisions Relating to Recommendations of the Commission on Capital Asset Realignment for Enhanced Services (CARES). On February 12, 2004, the CARES Commission issued a report to the Secretary of Veterans Affairs describing its recommendations for improvement or replacement of VA medical facilities, and the Secretary published his decisions relative to the Commission's recommendations in May 2004. With regard to the medical center, the Secretary concluded that:

"VA will maintain inpatient care services at the facility" and "will develop an implementation plan…that will include transition of surgery beds to observation beds for outpatient surgery. The implementation plan will also incorporate the recommendations of an ongoing, system-wide study of ICU [intensive care unit] beds scheduled to be completed in June 2004."

By 2012, the medical center will put new CBOCs into service in Milledgeville, Brunswick, and Perry, Georgia. Go to http://www1.va.gov/cares/ to see the complete text of the Secretary's decision.

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 medical center operations from September 2001 through September 22, 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:

Bulk Oxygen Utility System	Government Purchase Card Program
Contract Award and Administration	IT Security
Controlled Substances Accountability	Inventory Management
Emergency Preparedness	Moderate Sedation
Environment of Care	Property Transfer Agreement
Follow Up to Previous CAP Recommendations	QM

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. Web based questionnaires were made available to employees, 85 (11 percent) of whom responded. We also surveyed 50 patients during our site review. We provided the full survey results to medical center managers.

During the review, we also presented 4 fraud and integrity awareness briefings that were attended by 70 employees. 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.

An activity that was particularly noteworthy is recognized in the Organizational Strength section of this report (page 4). Activities needing improvement are discussed in the Opportunities for Improvement section (pages 5-11). For these activities, we make recommendations for improvement. Recommendations pertain to issues that are significant enough to be monitored by the OIG until corrective actions are implemented. For the activities not discussed in the Organizational Strength or Opportunities for Improvement sections, there were no reportable conditions.

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 medical center *(Combined Assessment Program Review of the Carl Vinson VA Medical Center, Report No. 00-0358-44, March 20, 2000).* In November 1999, we found that the Mental Health Service Line was in disarray, important clinical and administrative functions were deficient, and the environment of care needed improvement. In September 2004, we found that Mental Health services were operating effectively, clinical and administrative functions reviewed were improved, and the environment of care was clean and cheerful. Medical center managers adequately addressed recommendations made in the prior CAP report, and the previously cited conditions were corrected.

We also compared employee survey results from 1999 with those completed in 2004. In 1999, 80 employees responded to mail surveys, and in 2004, 85 employees responded to our web based survey. In 1999, 70 percent of employees reported they would recommend the medical center to an eligible family member or friend; in 2004, 85 percent would do so. In 1999, only 42 percent of responding employees said that quality of care at the medical center was fair, good, or excellent, while in 2004, 94 percent considered the quality of care fair, good, or excellent. Employee responses to similar questions indicated improved employee perceptions of patient care and workplace morale.

Results of Review

Organizational Strength

A Unique Property Transfer Agreement With the State of Georgia Enhanced Resources Available for Patient Care, and Expanded Veteran and Employee Benefits

In November 2000, Public Law No. 106-419 was passed, allowing the medical center to convey several buildings and approximately 100 acres of land to the Board of Regents of the state of Georgia and the Community Service Board (CSB) of Middle Georgia to be used for education and health purposes. The buildings and land consumed medical center resources for maintenance and upkeep but were not needed for medical center operations. Ceding the property allowed the medical center to redirect resources to patient care areas and activities.

As part of the property transfer agreement, employees and their dependents, as well as veterans enrolled for care at the medical center, receive tuition free education from Middle Georgia College through 2030. Currently, 43 employees or their dependents and 1 veteran patient are enrolled. Employees can also take advantage of the Employee Assistance Program and free counseling services offered by the CSB. Managers told us that they promote these educational and counseling benefits as part of the medical center's employee recruitment and retention efforts.

Opportunities for Improvement

Management of Moderate Sedation – Documentation Needed Improvement

Condition Needing Improvement. Clinicians did not consistently document patient evaluation and discharge instructions for patients receiving moderate sedation. The medical center's policy on the administration of anesthesia and sedation requires: i) a pre-anesthesia/sedation medical assessment within 30 days of the procedure; ii) a pre-anesthesia/sedation assessment and re-evaluation of the patient immediately prior to the administration of sedation; and iii) written discharge instructions provided to the patient or responsible party after the procedure. We reviewed 10 patient medical records and found that 1 patient did not have either the 30-day pre-sedation evaluation or re-evaluation immediately prior to the sedation. Additionally, three of nine[1] medical records did not contain discharge instructions as required.

Without appropriate documentation of patient assessment and discharge instructions, managers could not be assured that patients received safe and appropriate moderate sedation.

Recommended Improvement Action(s) 1. The VISN Director should ensure that the Medical Center Director requires that clinicians consistently perform and document pre-sedation evaluations and provide discharge instructions to all patients who receive moderate sedation.

The VISN and Medical Center Directors agreed with the findings and recommendations, and the VISN Director agreed with the Medical Center Director's corrective action plan. The Medical Center Director has instructed clinical staff to complete and document appropriate pre-sedation assessments, and provide patients or responsible parties with discharge instructions. We will follow up on the planned actions until they are completed.

Quality Management – Oversight of Committee Activities Needed Improvement

Condition Needing Improvement. Two important medical center wide committees did not adequately meet their oversight responsibilities. The Medical Executive Committee (MEC) monitors all matters concerning patient care and acts on reports from standing clinical committees.[2] The Quality Leadership Team (QLT) acts as a steering committee

[1] One patient was hospitalized at the time of the sedation and procedure; therefore, discharge instructions were not applicable.

[2] Standing clinical committees include the Operative and Invasive Procedure Committee, Medical Records Committee, and the Cardiopulmonary Resuscitation Committee, among others.

to oversee, develop, implement, and support the medical center's performance improvement process. The following conditions needed management attention.

The MEC Did Not Convene Monthly As Required. From September 2001 to September 2004, the MEC met only seven times, rather than monthly as required by medical center policy and medical staff by-laws. Since the MEC did not meet monthly to address areas under its purview, managers could not be assured that clinical activities were properly coordinated and actions or recommendations by subordinate committees were reviewed, discussed, approved, or implemented.

Oversight Committee Meeting Minutes Were Incomplete. Neither the MEC nor the QLT meeting minutes consistently reflected review of subordinate committees' reports, action plans to address deficiencies, or evaluations of the effectiveness of action plans.

- The MEC meeting minutes dated April 30, 2002, identified multiple surgical record documentation deficiencies, including untimely history and physical reports and incomplete post-operative notes. Clinical managers reported that corrective actions were implemented; however, subsequent MEC meeting minutes did not reflect evaluations of the effectiveness of corrective actions.

- The Cardiopulmonary Resuscitation (CPR) Committee met 5 times from July 18, 2003, to June 11, 2004, to review 33 code blue events. However, only one of eight subsequent QLT minutes reflected review and discussion of the CPR Committee's code blue reports. In one report, the CPR Committee noted that the process for returning used crash carts to Supply Processing and Distribution (SPD) was unclear. We found no evidence that the QLT evaluated this issue, or assured that appropriate follow up actions were implemented.

Based on interviews with service chiefs and other clinical managers, it appeared that the former Chief of Staff's informal management style, as well as a succession of Acting Chiefs of Staff since January 2004, contributed to the lack of committee oversight, documentation, and follow-up. A permanent Chief of Staff has been selected and was due to start in October 2004. Without regularly scheduled meetings and complete meeting minutes showing continuity of the committee oversight and follow-up process, managers could not be assured that corrective actions were appropriate, implemented, and effective.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the Medical Center Director requires that the: (a) MEC meet monthly as required; and (b) MEC and QLT provide improved oversight of clinical management and improved follow up of actions taken by subordinate committees.

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

The Medical Center Director has revised the MEC policy to require mandatory monthly meetings, and has agreed that the MEC's oversight functions will be properly documented in committee minutes. We will follow up on the planned actions until they are completed.

Controlled Substances Accountability – The Monthly Inspection Program and Inventory Controls Needed Improvement

Condition Needing Improvement. The medical center needs to improve controlled substances security and inventory management.

The Monthly Unannounced Controlled Substances Inspection Program Needed Improvement. Our review of the monthly unannounced inspection program found the following:

- Inspection reports did not describe what was reviewed during the inspection process, and some reports did not have supporting documentation.

- All inspection discrepancies were not reported to the Controlled Substances Program Coordinator.

- Inspectors did not check the expiration dates of drugs, nor did they require the pharmacist to verify that the manufacturers' seals were not broken on the inside of individual bottles. Internal controlled substances training did not direct inspectors to check for expiration dates of controlled substances to ensure that they were not distributed to wards and clinics.

- Not all controlled substances inspectors had appointment letters (9 of 18 inspectors) or documentation of yearly training (3 of 18 inspectors).

The Inventory Management Process Needed Improvement. Improvements are needed in the 72-hour inventory process, verification of the receipt and posting of controlled substances, and use of the prime vendor's inventory management tools.

- *72-Hour Inventories.* Our review of 72-hour inventory sheets found that pharmacists did not always indicate the actual number of controlled substances counted during inventories; discrepancies between the recorded inventories and the 72-hour inventory counts were not resolved; and inventory balance adjustments were not always made prior to the next inventory.

- *Accountable Officer.* The Acquisition and Materiel Management Service Accountable Officer verified controlled substances when received by the pharmacy. However, according to the Accountable Officer, postings were verified every 2 weeks, or if time permitted, during verification of receipt of the next shipment. As a

result, some of the controlled substances awaiting return to the prime vendor (see the next section) had not been entered into inventory, nor included in the monthly inspection process.

During our review, we found controlled substances on a table in the Inpatient Pharmacy vault. The controlled substances were left in open boxes since April 2004 while awaiting return to the prime vendor. Some of the drugs had not been entered into inventory and none were being accounted for during monthly unannounced inspections. The quantity included:

- 160 boxes of Meperdine 300mg.
- 50 boxes of Pentothal 500mg.
- 5 boxes of 40 unit doses of Morphine sulfate 20mg.
- 6 bottles (500 count each) of Propoxyphone 65mg.
- 38 Fentanyl 75mcg patches.
- 1 bottle (100 count) of Percocet 5mg.

Pharmacy Service did not have a control list for these controlled substances and, therefore, had no assurance that all the controlled substances awaiting return to the prime vendor were properly accounted for.

- *Prime Vendor Inventory Management Tools.* Pharmacy Service did not use the prime vendor inventory module to manage pharmacy inventories and did not maintain comprehensive inventory records to determine normal stock levels and reorder points, as required. Pharmacy Service managers used informal methods to determine normal stock levels and reorder points. According to the Chief, Pharmacy Service, the medical center will begin using the prime vendor inventory management tools once employees receive training, which was scheduled for October 2004.

Recommended Improvement Action(s) 3. The VISN Director should require that the Medical Center Director ensures that: (a) monthly controlled substances inspection reports are properly documented; (b) discrepancies identified during monthly inspections are reported to the Controlled Substances Program Coordinator; (c) inspectors are properly trained to conduct monthly inspections; (d) each controlled substances inspector receives an appointment letter and annual training relative to the appointment is documented; (e) 72-hour inventories are properly annotated to reflect actual counts of balances on hand; (f) 72-hour inventories are reviewed for discrepancies and balances are adjusted prior to the next inventory; (g) the Accountable Officer witnesses the receipt of controlled substances and posting of the inventory at the time of receipt; (h) controlled

substances awaiting return to the prime vendor are inventoried, accounted for, and inspected monthly; and (i) the prime vendor inventory module is used to manage pharmacy inventories.

The VISN and Medical Center Directors agreed with the findings and recommendations, and the VISN Director agreed with the Medical Center Director's corrective action plan. The Medical Center Director has developed a reporting template to ensure inspection of mandatory areas, documentation of identified discrepancies, review for expiration dates and intact seals, and reporting to the Controlled Substances Coordinator. Inspectors have received appointment letters and appropriate training. The Pharmacy Supervisor will verify inventory sheets and make adjustments as indicated. Pharmacists will use numbers rather than check marks to indicate the quantity of on-hand narcotics agrees with the computerized balance. The Accountable Officer is verifying the receipt and posting of controlled substances at the same time, and documenting receipt or return actions in a logbook. The Prime Vendor Inventory Module will be implemented by March 1, 2005. We will follow up on the planned actions until they are completed.

Information Technology – Security Needed Improvement

Condition Needing Improvement. Medical center management needs to improve IT contingency and security planning and system administration.

The Medical Center's Contingency Plans Were Not Comprehensive. Contingency plans for the Veterans Health Information Systems and Technology Architecture (VistA), Local Area Network (LAN), Computerized Public Branch Exchange, and Service Sections were not comprehensive and lacked key elements required by VA and the Veterans Health Administration (VHA). The following conditions required management attention:

- *Alternate Processing Sites Were Not Identified in the Medical Center's Contingency Plans.* The medical center established an Alternate Processing Site agreement with the Augusta VA Medical Center on July 7, 2004. However, the site had not been included in the medical center's contingency plans as directed by VA and VHA policy. We also found that the agreement was not consistent with National Institute of Standards and Technology (NIST) Memorandum of Agreement (MOA) guidelines and several key elements were missing.

- *The Application Analysis Form Was Not Completed.* The Application Analysis Form (Appendix B) for applicable medical center services was not completed. Completion of the form allows Information Resources Management Service to prioritize the order in which applications would be restored in the event of a major disaster. VA policy recommends the use of Appendix B, listed in the VA Office of Cyber and Information Security (OCIS) contingency plan guide, as a resource to organizing, developing, testing, and implementing a contingency plan.

Contingency Plans Tests Were Not Documented. The Information Security Officer (ISO) stated that the contingency plans had been tested but had no documentation of the test results. VHA policy requires that contingency plans are tested annually and the results documented. Lack of documentation of test results inhibits management's ability to correct identified recovery issues.

VistA and LAN System Security Plans (SSPs) Were Not Comprehensive. The SSPs did not describe comprehensive management, operational, and technical controls. The ISO should use the OCIS template to ensure that the medical center's plans comply with VA and VHA policy.

Annual Software Inventories Were Not Conducted. The medical center did not inventory and maintain written records of all software on each individual personal computer, as required by VA policy. As a result, there was no assurance the medical center had licensing agreements for all software in use.

Personal Services Contracts Were Not Reviewed and Approved by the ISO. The ISO did not review personal services contracts to ensure they contain appropriate information security provisions, as required by VA policy.

Security Awareness Training Was Not Provided to All Medical Center Staff. The medical center had provided annual security awareness training to only 619 of 796 (78 percent) medical center staff in FY 2004. VHA policy requires that all staff receive training annually. Additionally, the ISO could not provide documentation that any of the contracted employees had received required annual security awareness training.

Background Investigations. The ISO did not maintain documentation identifying contract personnel with LAN access. As a result, background investigations were not requested for 42 of 66 (64 percent) current contract employees with LAN access, as required by VA policy.

Recommended Improvement Action(s) 4. The VISN Director should require that the Medical Center Director ensures that: (a) comprehensive contingency plans and SSPs are developed; (b) the MOA is consistent with NIST guidelines and Application Analysis Forms for applicable services are completed; (c) contingency plan testing is conducted and documented in accordance with VHA policy; (d) annual software inventories are conducted and written records of all software on each individual personal computer are maintained; (e) the ISO reviews all personal services contracts to ensure they contain appropriate information security provisions; (f) annual security awareness training is provided to all medical center staff and contractor employees; and (g) background investigations are completed for all contract employees with access to sensitive VA information systems.

The VISN and Medical Center Directors agreed with the findings and recommendations, and the VISN Director agreed with the Medical Center Director's corrective action plan. The Medical Center Director has initiated revision of the contingency plans, begun staff training, developed an MOA for an alternate processing site, and created an action plan for contingency plan testing. VistA and LAN security plans have been revised to include necessary elements, including software-licensing requirements. Personal services contracts will be reviewed prior to release. The Healthcare Education System (SynQuest) will be reviewed to ensure employees have received training, and to document and track contractor training. Background investigations will be completed and documented for contractors accessing the computer system. We will follow up on the planned actions until they are completed.

Inventory Management – Usage Data Was Not Included in All Inventory Point Databases

Condition Needing Improvement. Operations Service Line staff did not enter stock item usage data into databases for all inventory points. Also, the Generic Inventory Package (GIP) automatic level setter feature was not used to establish stock levels and reorder points, and was not used to manage inventories.

There were 5 primary inventory points (SPD, Engineering, Environmental Management Service, Nonmedical, and Process Store) that had 1,155 stock items with on-hand balances. We found that 327 (28 percent) of the stock items did not have usage data in the inventory point databases.

While GIP had usage data for the remaining 828 stock items, inventory point managers did not use GIP's automatic level setter feature to establish stock levels and reorder points. The Operations Service Line Manager told us that the automatic level setter feature could be used to manage the stock and only those items that had problems would be managed manually.

Because the inventory points did not contain usage data, we could not determine the reasonableness of the established stock levels or that the on-hand balances did not exceed a 30-day level.

Recommended Improvement Action(s) 5. The VISN Director should require that the Medical Center Director ensures that: (a) usage data is entered into GIP; (b) the automatic level setter feature is used to manage the inventories; and (c) stock levels do not exceed a 30-day level.

The VISN and Medical Center Directors agreed with the findings and recommendations, and the VISN Director agreed with the Medical Center Director's corrective action plan. The Medical Center Director established GIP primary and secondary inventory points, and will ensure that receipts and distribution transactions are posted in GIP. The user

level will be adjusted using the automatic level setter when stock levels exceed 30 days. We will follow up on the planned actions until they are completed.

Appendix A

VISN 7 Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 15, 2004

From: Director, Veterans Integrated Service Network (10N7)

Subject: **Combined Assessment Program Review of the Carl Vinson VA Medical Center, Dublin, Georgia, Project Number: 2004-03028-HI-0361**

To: Director, Office of Inspector General

Thru: Director, Management Review Office (105B)

1. We have reviewed the draft report of the Inspector General's Combined Assessment Program (CAP) of the Carl Vinson VA Medical Center. We concur with the findings and recommendations of the review and I concur with all the comments and planned actions.

2. I appreciate the opportunity for this review as a continuing process to improve the care to our veterans.

3. If you have any questions or need any additional information, please contact Wayne Saxon at (678) 924-5719.

(original signed by:)
Linda F. Watson

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: November 15, 2004

From: Director, Carl Vinson VA Medical Center (557/00)

Subject: **Combined Assessment Program Review of the Carl Vinson VA Medical Center, Dublin, Georgia, Project Number: 2004-03028-HI-0361**

To: VISN Director

1. I have reviewed the draft report of the Inspector General's Combined Assessment Program (CAP) of the Carl Vinson VA Medical Center. I concur with the findings and recommendations.

2. The following draft report is our comments and planned actions for improving the care to our veterans as well as answering the recommendations made by the review team.

(original signed by:)
Richard W. Fry

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 ensure that the Medical Center Director requires that clinicians consistently perform and document pre-sedation evaluations and provide discharge instructions for all patients who receive moderate sedation.

Concur **Target Completion Date:** Completed

Corrective Action: Staff have been instructed that prior to the administration of anesthesia, the preoperative Checklist will be completed using the following criteria:

(a) Each patient who receives anesthesia care will have a pre-sedation/anesthesia assessment documented into the Computerized Patient Record System (CPRS) within 30 days prior to the procedure.

(b) Prior to discharge, a post-operative checklist will be completed by Nursing. Patients meeting discharge criteria will receive written instructions prior to discharge from the facility. Appropriate sheets with instructions will be given to the patient or responsible party, and appropriate documentation provided in the computerized patient record. The process will be monitored weekly and reported monthly to the Quality Leadership Team.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the Medical Center Director requires that the: (a) MEC meets monthly as required; and (b) MEC and QLT provide improved oversight of clinical management and improved follow up of actions taken by subordinate committees.

Concur **Target Completion Date:** Completed

Corrective Action:

(a) Medical Center Memorandum (MCM) 00-134 titled, "Medical Executive Committee" (MEC) has been revised to show necessary changes to ensure that MEC will meet monthly as required. Required meetings will be held the second Thursday of each month at 3 p.m. Meetings are mandatory for all members.

(b) The MEC will provide oversight of reporting corrective actions and evaluation of effectiveness of corrective actions as documented in minutes.

Recommended Improvement Action(s) 3. The VISN Director should require that the Medical Center Director ensures that: (a) monthly controlled substances inspection reports are properly documented; (b) discrepancies identified during monthly inspections are reported to the Controlled Substances Program Coordinator; (c) inspectors are properly trained to review for expiration dates of controlled substances during the monthly inspections; (d) each controlled substances inspector receives an appointment letter and annual training relative to the appointment is documented; (e) 72-hour inventories are properly annotated to reflect actual counts of balances on hand; (f) 72-hour inventories are reviewed for discrepancies, and balances are adjusted prior to the next inventory; (g) the Accountable Officer witnesses the receipt of controlled substances and posting of the inventory at the time of receipt; (h) controlled substances awaiting return to the prime vendor are inventoried, accounted for, and inspected monthly; and (i) the prime vendor inventory module is used to manage pharmacy inventories.

Concur **Target Completion Date:** 3/1/05

Corrective Action:

(a) A reporting template has been developed that requires inspectors to properly document that they have inspected all mandatory areas required by Controlled Substance Inspection Program (CSI) requirements. (Completed)

(b) The reporting template ensures inspectors report and annotate all discrepancies in detail on the CSI report and submit to the Controlled Substance Coordinator. (Completed)

(c) All 2004 inspectors have achieved certification and training on reviewing expiration dates on all controlled substances. Reporting template was revised to reflect separate action for expiration dates and intact seals. (Completed)

(d) All new inspectors will have appointment letters and documented training on the Controlled Substance Inspection process. Target date: 1/1/05

(e) The Pharmacy Supervisor will review and verify every Inventory Sheet for accuracy. All pharmacists have been counseled to write the numerical number in the "on-hand" space instead of using a check mark to indicate quantity on hand agrees with current computerized balance. (Completed)

(f) The Pharmacy Supervisor is now reviewing all inventory sheets and making adjustments to the inventory prior to the next 72-hr inventory. (Completed)

(g) The Accountable Officer is now verifying the receipt and posting of all controlled substances at the same time. (Completed)

(h) A log book has been established containing a copy of the invoice signed by the pharmacist and Accountable Officer indicating receipt and request to return. (Completed)

(i) Prime Vendor Inventory module will be used to manage pharmacy inventories. The Prime Vendor Interface will be loaded to interface with Drug Accountability package and invoices. Target date: 3/1/05

Recommended Improvement Action(s) 4. The VISN Director should require that the Medical Center Director ensures that: (a) comprehensive contingency plans and SSPs are developed; (b) the MOA is consistent with NIST guidelines and Application Analysis Forms for applicable services are completed; (c) contingency plan testing is conducted and documented in accordance with VHA policy; (d) annual software inventories are conducted and written records of all software on each individual personal computer are maintained; (e) the ISO reviews all personal services contracts to ensure they contain appropriate information security provisions; (f) annual security awareness training is provided to all medical center staff and contractor employees; and (g) background investigations are completed for all contract employees with access to sensitive VA information systems.

Concur **Target Completion Date:** 1/15/05

Corrective Action:

(a) Office of Cyber Information Security templates will be used to incorporate the revised VISTA Contingency Plan at the facility and service levels. The ISO has begun training sessions and will continue to meet with every Service Section until all sections have included key elements in service level contingency plans. Target date: 1/15/05

(b) A Memorandum of Agreement between Carl Vinson VAMC and Augusta VAMC for an Alternate Processing Site is in process which includes the Recoverall Process and inclusion of Augusta VAMC as the VISTA alternative contingency site. Target date: 1/15/05

(c) Contingency Plan Training & Testing action plan is in place and includes ADPAC instructions, application documents for completion, and effectiveness of contingency plan testing. (Completed)

(d) VISTA and LAN Security Plans have been revised to include drawings and detailed explanation for each required area and were completed on the VA OCIS template. A Software Inventory action plan is in place and outlines procedures to perform annual software inventory. The process will ensure compliance with all software licensing and applicable regulations, and System Management Server will be used as a tool to perform software inventory. The equipment includes PCs and work stations i.e. laptops not physically connected to the LAN. (Completed)

(e) Representatives from Contracting, ISO, Human Resources, Risk Management, and Primary Care have been instructed to ensure in the future the VISN 7 Logistics Manager and the VISN 7 ISO will ensure review of personal services contracts prior to release. Target date: 12/1/04

(f) The ISO will review the Healthcare Education System (SynQuest) quarterly to ensure all employees are compliant. For contractors, accessing our computer system, a plan has been implemented to add the functionality to SynQuest to track their training and accomplish 100% compliance. (Completed)

(g) Carl Vinson VAMC Contracting, ISO, Human Resources, Risk Management, and Primary Care managers will include documentation that the requirement for Contract Background Investigation is adhered to. Target date 1/15/05.

Recommended Improvement Action(s) 5. The VISN Director should require that the Medical Center Director ensures that: (a) usage data is entered into GIP; (b) the automatic level setter feature is used to manage the inventories; and (c) stock levels do not exceed a 30-day level.

Concur **Target Completion Date:** Completed

Corrective Action:

(a) GIP primary and secondary inventory points are established and used with each of the inventory points. All receipt and distribution transactions for any item included in any of the Primary Inventory Points should be posted in GIP, without exception. If corrective action is needed, the action

will be forwarded to the Associate Director for follow-up or tracking.

(b) The stock levels of inventory have been established based on recommendations from the users. The automatic level setter will be used and the 30 day stock level adhered to.

(c) When stock levels exceed 30 days the user level is adjusted per policy.

OIG Contact and Staff Acknowledgments

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Appendix D

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