Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Central Iowa Health Care System Des Moines, Iowa

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VA Office of Inspector General
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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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Introduction

During the week of February 28–March 4, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Central Iowa Health Care System. The purpose of the review was to evaluate selected operations, focusing on patient care administration, quality management (QM), and financial and administrative controls. During the review, we also provided fraud and integrity awareness training to 112 health care system employees. The health care system is part of Veterans Integrated Service Network (VISN) 23.

Results of Review

The CAP review covered 16 operational activities. The health care system complied with selected standards in the following four activities:

- Community Nursing Home Contracts
- Equipment Accountability
- Government Purchase Card Program
- Part-Time Physician Timekeeping

Twelve activities needed management attention. To improve operations, the health care system needed to:

- Request preaward audits for service contracts and properly review contract price reasonableness and contractor invoices.
- Correct deficiencies in the canteen food service and storage areas.
- Reduce delays in insurance billings and collections and improve clinical documentation needed for insurance bills.
- Reduce excess supply inventories and strengthen inventory management controls.
- Improve compliance with the supply purchasing hierarchy.
- Strengthen pharmacy security and drug accountability controls.
- Improve the cleanliness of patient care areas.
- Strengthen controlled substances accountability controls.
- Improve controls over the prevention and management of pressure ulcers.
- Develop automated information systems (AIS) contingency plans and terminate inactive access accounts.

- Strengthen emergency preparedness physical security vulnerabilities and provide training.
- Analyze QM data and make recommendations for improvement.

VISN 23 and Health Care System Director Comments

The VISN and Health Care System Directors agreed with the CAP review findings and provided acceptable improvement plans. (See Appendixes A and B, pages 19–33, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed. This report was prepared under the direction of Mr. David Sumrall, Director, and Ms. Myra Taylor, CAP Review Coordinator, Seattle Audit Operations Division.

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

Introduction

Health Care System Profile

Organization. The VA Central Iowa Health Care System has two divisions located in Des Moines and Knoxville, IA, and provides medical, surgical, psychiatric, and long-term care services. Outpatient care is also provided at two community-based outpatient clinics (CBOCs) in Mason City and Fort Dodge, IA. The health care system serves a population of about 115,000 veterans in 40 counties of central Iowa and northern Missouri.

Programs. The Des Moines Division is an 85-bed facility, providing a full range of services in medicine, surgery, and psychiatry. The Knoxville Division is a 320-bed facility that provides mental health inpatient services, a nursing home, and a domiciliary. Special programs include Substance Abuse, Post-Traumatic Stress Disorder, and Subacute and Restorative Rehabilitation.

Affiliations. The health care system is affiliated with the University of Iowa Roy J. and Lucille A. Carver College of Medicine and supports 17 medical resident positions in 4 training programs.

Resources. The health care system's fiscal year (FY) 2005 medical care budget was $151.3 million, a 3 percent increase over FY 2004 funding of $146.8 million. FY 2004 staffing was 1,156 full-time equivalent employees (FTE), including 41 physician FTE and 291 nursing FTE.

Workload. In FY 2004, the health care system treated 31,955 unique patients, a 7 percent increase from FY 2003. The FY 2004 inpatient average daily census, including nursing home patients, was 267, and outpatient workload totaled 274,582 patient visits.

Decisions Relating to Recommendations of the Commission on Capital Asset Realignment for Enhanced Services. On February 12, 2004, the Commission on Capital Asset Realignment for Enhanced Services issued a report to the former Secretary of Veterans Affairs providing its recommendations for improvement or replacement of VA medical facilities. In May 2004, the former Secretary published his decisions on the commission's recommendations. As a result of the former Secretary's decisions, VA will transfer inpatient care from the Knoxville Division to the Des Moines Division. By transferring acute psychiatry, intermediate medicine, domiciliary, and nursing home care services from Knoxville to the Des Moines Division, VA will avoid costly renovations to aging buildings at Knoxville. Moving inpatient care from Knoxville to Des Moines will also improve care coordination by enhancing interdisciplinary collaboration through collocation. Acute and long-term psychiatry will be collocated with other acute care services, and nursing home services will be moved closer to the state population center. Nursing home services will also be improved by constructing a new state-of-the-art

nursing building at the Des Moines Division that will improve the environment of care. The Knoxville Division will continue to provide outpatient care services.

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, QM, 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 management controls. Patient care administration is the process of planning and delivering patient care. QM is the process of monitoring the quality of care to identify and correct harmful and potentially harmful practices and 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.

In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered the following 16 activities:

Canteen Food Service and Storage
Community Nursing Home Contracts
Controlled Substances Accountability
Emergency Preparedness
Environment of Care
Equipment Accountability
Government Purchase Card Program
Information Technology Security
Medical Care Collections Fund
Part-Time Physician Timekeeping
Pharmacy Security and Drug Accountability
Pressure Ulcer Prevention and Management
Procurement of Medical and Prosthetic Supplies
Quality Management Program
Service Contracts
Supply Inventory Management

The review covered health care system operations for the period FY 2001 to FY 2005 through March 2005 and was done in accordance with OIG standard operating procedures for CAP reviews. We also followed up on selected recommendations of our prior CAP review of the health care system (*Combined Assessment Program Review of the VA Central Iowa Health Care System*, Report No. 00-01229-102, June 13, 2001).

As part of the review, we used questionnaires and interviews to survey patient and employee satisfaction with the timeliness of service and the quality of care. We made electronic survey questionnaires available to all employees, and 190 employees responded. We also interviewed 30 patients during the review. We discussed the survey and interview results with health care system managers.

During the review, we also presented 3 fraud and integrity awareness briefings for 112 employees. These 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.

Results of Review

Opportunities for Improvement

Service Contracts – Preaward Audits Should Be Requested and Price Reasonableness and Contractor Invoices Properly Reviewed

Conditions Needing Improvement. Management needed to ensure that sole source contracts valued at $500,000 or more are sent to the VA OIG for preaward audits, prices for sole source contracts are fair and reasonable, and contracting officer's technical representatives (COTRs) properly review contractor invoices before certifying them for payment. To determine if contract administration procedures were effective, we reviewed 10 service contracts (value = $12.3 million) and interviewed the health care system's 2 contracting officers and 6 COTRs.

Preaward Audits of Sole Source Contracts Not Requested. Veterans Health Administration (VHA) policy requires that sole source contracts valued at $500,000 or more be sent to the OIG for preaward audits. The primary purpose of these audits is to determine whether the prices are fair and reasonable in accordance with the Federal Acquisition Regulation. Five contracts (value = $7.7 million) met the dollar threshold but were not sent for the required audits.

Fair and Reasonable Pricing Not Determined. For the sole source contract for anatomic pathology services (value = $772,506), contracting staff had not performed the required cost or price analysis to determine whether contract prices were fair and reasonable. The contracting staff acknowledged that they had not reviewed any cost or pricing information and had instead relied on the Pathology and Laboratory Service staff's assessment that the contract was fair.

Contractor Invoices Not Properly Reviewed. For each contract, the contracting officer designates a COTR who is responsible for monitoring the contractor's performance and ensuring that services are provided in accordance with the contract. This responsibility includes reviewing contractor invoices and certifying that the charges accurately reflect the work completed.

Contract monitoring was effective for 8 of the 10 contracts reviewed. However, monitoring procedures for the pain management and the CBOC pharmaceutical services contracts needed improvement. The COTRs for these two contracts had certified contractor invoices without reviewing them to ensure that the charges were correct. We reviewed a sample of invoices but could not determine if charges were correct because the invoices lacked pertinent detailed information, such as patient names or procedure codes. Because the COTRs are responsible for ensuring that charges are correct, they should require the contractors to provide more detailed information on the invoices.

Recommendation 1. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) all sole source contracts valued at $500,000 or more be submitted to the VA OIG for preaward audits, (b) cost or price analysis be performed for all sole source contracts, (c) refresher training be provided to the COTRs on responsibilities and procedures for properly certifying invoices, and (d) pain management and CBOC pharmaceuticals contractor invoices paid in FY 2005 be reviewed to ensure that all charges were correct.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that the contracting staff have been instructed to follow the preaward and cost or price analysis requirements. In our draft report, we estimated that preaward audits for the five sole source contracts could have resulted in reduced costs of about $1.0 million. Since the Health Care System Director provided evidence that steps were taken to evaluate price reasonableness, we have not included potential savings based on an OIG preaward audit. COTRs will receive refresher training on procedures for certifying and paying invoices. All training will be completed by June 30, 2005. Further, the contracting officers will review the pain management and CBOC pharmaceutical services contractor invoices paid in FY 2005. The target date to complete this review is May 31, 2005. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Canteen Food Service and Storage – Deficiencies Needed To Be Corrected

Conditions Needing Improvement. Managers needed to ensure that the Veterans Canteen Service (VCS) food service and storage areas are clean, secure, free from mold, and comply with VCS standards. We inspected the Knoxville Division's VCS food service and storage areas for general cleanliness, safety, and maintenance. We found five deficiencies that needed to be corrected.

Cleanliness Deficiencies. Food service and storage areas must receive regular cleaning and maintenance to ensure staff and food safety. During our inspection, we found the following problems:

- Rusted and dust-covered floor fan blowing toward the food preparation and service line
- Rusted step stools without lock/safety devices
- A dirty housekeeping cart, soiled and clean mops, and brooms stored in the dish washing room
- Heavy buildup of dust on window ledges and on top of a stainless utensil holder in the dining room
- Rusted and dirty shelves containing VCS merchandise in the storage rooms

- Broken glass between shelves on the floors in food and merchandise storage rooms
- Heavy debris on floors between shelves in the storage rooms (possible pest activity)

Unlocked Kitchen Door. We found the door to the VCS kitchen unlocked and the kitchen, where knives and food were accessible, unattended. To prevent unauthorized access to the kitchen and to ensure staff and food safety, the door should be kept locked.

Presence of Mold. Mold can contaminate food service and storage areas and lead to health problems. We observed mold on ceiling tiles in storage rooms, around windows and behind wallpaper in the dining room, and on cement walls and window ledges in the merchandise storage room. At our request, the Pathology and Laboratory Service cultured four samples of the molds and determined that they were potentially dangerous to people with compromised immune systems.

Photograph 1. Mold behind wallpaper in the dining room.

Inadequate Temperature Controls. Refrigerators and freezers are required to be maintained within acceptable temperature ranges to keep food safe for consumption. Refrigerator temperatures should be 34 to 41 °F, and freezer temperatures should be 0 to -10 °F. At the time of our inspection, the temperature for a VCS food service refrigerator was 49 °F. In addition, the health care system needed to correctly program the thermometers used to report the internal temperature of the refrigerators and freezers and to display what the acceptable temperature range should be. (These thermometers did not control the refrigerator or freezer temperatures.) The acceptable temperature ranges displayed on thermometers for several refrigerators and freezers had been improperly programmed. For example, the acceptable temperature range for one refrigerator's thermometer in the VCS food service area had been incorrectly programmed to be 41 to 58 °F. Properly programming the thermometers would make it easier for canteen employees to identify unacceptable temperatures and initiate corrective action.

Photograph 2. Unsealed opening in ceiling of food storage area.

Unsealed Openings in Ceiling. In the food service and storage areas, there were several places where ceiling tiles had been cut to allow the installation of pipes and electrical conduit. Areas between the pipes or conduit and the tiles had not been sealed, leaving open spaces. These spaces should be sealed to prevent the entry of pests and dust and to ensure that fragments from the cut tiles do not contaminate food.

Recommendation 2. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) the VCS food service and storage areas be kept clean and effectively managed, (b) the VSC kitchen door be kept locked, (c) food service and storage areas be mold-free, (d) refrigerator temperatures and thermometers be properly programmed, and (e) areas between ceiling tiles and pipes or conduit be appropriately sealed.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that plans had been implemented to increase the monitoring of the cleanliness and management of the food service and storage areas and to keep the kitchen door locked. Health care system staff removed the mold, reviewed the refrigerator temperatures, and received training on resetting the thermometers. The areas between the ceiling tiles and pipes or conduit were to be sealed by April 28, 2005.

Medical Care Collections Fund – Billing and Collection Delays Should Be Reduced and Clinical Documentation Improved

Conditions Needing Improvement. Under the Medical Care Collections Fund (MCCF) program, VA may recover from health insurance companies the cost of treating certain insured veterans. Health care system management needed to ensure that insurance bills are issued promptly, outstanding bills are pursued aggressively, and clinical documentation is completed.

Insurance Bills Not Issued Promptly. As of December 31, 2004, the health care system had 4,549 unbilled episodes of outpatient care (value = $474,612). For FY 2004, average monthly billing delays ranged from 45 to 168 days. The average time to initiate a bill was 78 days, exceeding by 28 days the VA benchmark of 50 days.

Insurance Bills Not Promptly Followed Up. Before FY 2004, the Omaha Centralized Collection Unit of the VA Nebraska Western Iowa Health Care System was responsible for MCCF collections for the health care system. Because of this, we excluded bills older than 365 days from our review and reviewed only the insurance bills that the health care system was responsible for collecting. As of December 31, 2004, the health care system had 12,161 such bills with a total value of $2.5 million (excluding bills referred to the VA Regional Counsel for collection and those greater than 365 days). Of these, 4,993 bills (value = $846,378, or 34 percent of the total value) were more than 90 days old.

To evaluate collection efforts, we reviewed a judgment sample of 20 bills (value = $99,973) that were more than 90 days old. Six of these bills had been appropriately cancelled, reissued, or collected after we began our review of the sample. However, based on our review and discussions with the Business Office Manager the remaining 14 bills (value = $80,290, or 80 percent of the $99,973 total value) required more aggressive collection actions.

MCCF staff took an average of 117 days from the billing dates before making follow-up telephone calls to insurers to determine why payments had not been received. VA policy requires staff to initiate follow-up telephone calls within 30 days of the billing date. To aggressively pursue bills, multiple collection letters should be sent and follow-up telephone calls should be made. Based on discussions with the Business Office Manager, we estimated that if MCCF staff pursued bills more aggressively they could increase the collection rate by at least 5 percent. This would provide additional revenue of $33,855 ($846,378 in bills older than 90 days x 80 percent sample result x 5 percent increase in collections = $33,855).

Clinical Documentation Not Adequate. During the 6-month period July–December 2004, MCCF staff cancelled 90 bills (value = $13,115) because attending physicians did not provide sufficient clinical documentation, such as progress notes. We reviewed a judgment sample of 50 bills (value = $11,793) that had been cancelled because of insufficient documentation and determined that 40 (80 percent) had collection potential. As a result of our review, MCCF staff began analyzing these claims and plans to reissue bills as appropriate. Using the health care system's historical collection rate of 23 percent, we estimated that better documentation would have resulted in additional revenue of $2,413 ($13,115 in bills with insufficient documentation x 80 percent sample result x 23 percent collection rate = $2,413).

In summary, we estimated that MCCF staff could have increased collections by $36,268 ($33,855 from aggressively pursuing insurance receivables + $2,413 from better clinical documentation = $36,268).

Recommendation 3. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) insurance bills be issued promptly, (b) insurance bills be pursued more aggressively, and (c) medical records include adequate clinical documentation.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that plans had been implemented to ensure insurance bills are issued promptly and aggressively pursued. In addition, by July 2005 a new process will be implemented to ensure clinical documentation is complete and sufficient. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Improved

Conditions Needing Improvement. VHA establishes a 30-day supply goal and requires that medical facilities use VA's Generic Inventory Package (GIP) to manage inventories of most types of supplies. We evaluated health care system management of medical, prosthetic, and engineering supplies to determine if controls were adequate to prevent the

build up of excess inventory. We concluded that stock levels for prosthetic supplies were adequate. However, the health care system needed to reduce excess inventories of medical and engineering supplies and make better use of automated controls to more effectively manage supply inventories.

Excess Medical Supply Inventory. Supply, Processing, and Distribution (SPD) Section staff used GIP to manage medical supply inventory. As of March 1, 2005, the SPD inventory consisted of 3,528 line items with a value of $123,486. To test the reasonableness of inventory levels, we reviewed a judgment sample of 20 items (value = $4,727). For 4 of the 20 items, the stock on hand exceeded a 30-day supply, with inventory levels ranging from 75 to 396 days of supply. The estimated value of stock exceeding 30 days was $527, or 11 percent of the total value of the 20 items. By applying the 11 percent estimate of excess stock for the sampled items to the entire stock, we estimated that the value of the medical supply inventory exceeding a 30-day supply was $13,583 (11 percent of the total inventory value). The excess stock occurred because staff were not properly recording transactions, monitoring supply usage rates, or adjusting GIP stock levels to meet the 30-day standard.

In addition to reducing inventory, SPD staff needed to improve the accuracy of GIP data. Using the sample of 20 medical supply items, we compared the recorded GIP quantities on hand with our actual counts. GIP inventory records were not accurate for 4 (20 percent) of the 20 items. For the four items, transactions had been inaccurately or incompletely posted to inventory records, resulting in inaccurate inventory balances. If inventory balances are not kept current, GIP cannot accurately track item demand or establish reasonable stock levels and reorder points.

Excess Engineering Supply Inventory. Materiel Management Section was not using GIP to manage engineering supplies. To evaluate the reasonableness of the engineering supply inventory, we reviewed the quantities on hand for a judgment sample of 10 items (estimated value = $4,473). Because the service was not using GIP, we asked responsible staff to estimate usage rates for the 10 items. Stock on hand exceeded the 30-day goal for all 10 items, with inventory levels ranging from 61 days to several years of supply. Without sufficient inventory records, we could not determine the value of all engineering supplies or the amount of inventory that exceeded a 30-day supply. Health care system management acknowledged the need to reduce the inventory and to fully implement GIP controls for all engineering supplies.

Recommendation 4. We recommended that the VISN Director ensure that the Health Care System Director requires: (a) SPD staff to properly control stock and prevent excess medical supply inventory and keep GIP inventory records current by promptly and accurately posting inventory transactions and (b) Materiel Management Section staff to reduce excess engineering supply inventory and implement GIP for all engineering supplies.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that plans were being implemented to automate inventories and increase their accuracy. The target date for full implementation of these plans is December 2006. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Procurement of Medical and Prosthetic Supplies – Purchases Needed To Comply with VA's Purchasing Hierarchy

Condition Needing Improvement. Management needed to ensure that medical and prosthetic supplies are purchased in compliance with VA's purchasing hierarchy. VA policy requires medical facilities to purchase supplies according to the hierarchy, which organizes vendors from the most to least preferred sources as follows: national contracts and Blanket Purchase Agreements (BPAs), local BPAs, Federal Supply Schedule (FSS) contracts, local non-FSS contracts, and open market purchases.

To determine if the health care system purchased medical and prosthetic supplies effectively, we selected a judgment sample of 20 supply products and reviewed purchases of these products for the 6-month period July–December 2004. The 20 products included 10 medical products (such as anti-embolism stockings and skin closures) and 10 prosthetic products (such as continuous positive airway pressure machines and nebulizers).

During the review period, the health care system purchased 18 of the 20 products.[1] For the 18 products, the health care system made 282 purchases at a total cost of $223,559. Seven (39 percent) of the 18 products were not purchased in accordance with the hierarchy. Four of these products should have been purchased from national BPAs, and the other three should have been purchased from FSS contracts. The health care system made 131 purchases of these 7 products at a total cost of $30,455. If these purchases had been made from the preferred hierarchy sources, the cost would have been $24,736, a savings of $5,719 (19 percent of costs for the 7 products and 3 percent of costs for the 18 products).

National BPAs Not Used. The health care system purchased four of the seven products from higher priced FSS and open market sources instead of from the available BPAs. The four products were adult diapers, disposable nasal cannulas, sharps disposal containers, and adhesive skin closures. The health care system paid $25,307 for these four products but would have paid $20,407 if the products had been purchased from the BPAs, a savings of $4,900 (19 percent). The following example illustrates the cost savings for one BPA item:

[1] The 20 products were selected for a planned OIG audit that will focus on supply purchasing practices at VA medical facilities. We will evaluate these practices as part of selected CAP reviews conducted during FY 2005 and will summarize the results in an audit report. The sampled products that the health care system did not purchase were regular disposable scalpels and portable ramps.

Disposable Nasal Cannulas. The BPA for disposable nasal cannulas offered 7-foot and 14-foot cannulas. Although the health care system purchased 950 7-foot cannulas from the BPA at a cost of $412 ($0.43 each), they did not purchase 14-foot cannulas from the BPA. During the review period, the health care system bought 1,050 14-foot cannulas from an open market source at a cost of $1,280 ($1.22 each). The BPA cost would have been $787 ($0.75 each), a savings of $493 (39 percent). The purchasing agent did not know 14-foot cannulas were available from the BPA.

FSS Contracts Not Used for Three Products. The health care system purchased three products from open market sources instead of from FSS contracts. The three products were disposable skin staplers, tub benches, and toilet seats, and the total cost of the open market purchases of these products was $5,148. If these products had been purchased from FSS contract sources, the cost would have been $4,329, a savings of $819 (16 percent).

Training Not Provided and Hierarchy Not Understood. VHA requires that all procurement staff receive training on the purchasing hierarchy. We reviewed training documentation and determined that 6 (40 percent) of the 15 procurement staff had not received the required training. According to the VISN's current Chief Logistics Officer (CLO), the six employees had not been trained because the former CLO had misinterpreted the VHA policy, believing that only contracting officers and purchasing agents required the training. The current CLO agreed that the six employees (three inventory management specialists, two supply technicians, and one program support clerk) should have received the training since all purchase medical supplies.

We also interviewed 10 of the procurement staff to assess their knowledge of the purchasing hierarchy. Six (60 percent) of the 10 could not explain the hierarchy and were unaware that national contracts and BPAs were the 2 most preferred sources. To further assess their knowledge of the hierarchy, we asked all 10 to identify the best vendors for 2 items, 1 available from a BPA and 1 available from FSS sources. Six did not know the first item was available on a BPA, and none knew the second item was available from FSS sources.

Recommendation 5. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) supply products be purchased according to the VA purchasing hierarchy and (b) all procurement staff receive initial and refresher training on the purchasing hierarchy.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that purchases will be monitored for compliance with the VA purchasing hierarchy. Refresher training on the hierarchy was to be provided to staff

by April 29, 2005. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Pharmacy Security and Drug Accountability – Controls Should Be Strengthened

Conditions Needing Improvement. To evaluate pharmacy security and drug accountability, we inspected pharmacy storage and clinical areas; interviewed Police Service staff, the Chief of Pharmacy Service, and nursing staff; and reviewed Police Service reports and medication administration records. For most pharmacy areas, access controls were effective and physical security was adequate. However, at a Des Moines Division clinic, we identified three deficiencies that needed correction.

Unlocked Medication Cart. During our inspection of the clinic, the medication cart was locked. However, several employees told us that this cart was often left unlocked, leaving the drugs vulnerable to theft and/or tampering. In addition, during the 11-month period April 2004–February 2005, the health care system's own inspections found the medication cart unlocked four times.

Drug Removals Not Logged Consistently. Clinical staff were not following a local procedure requiring them to document in a logbook removals of drugs from the medication cart.

Discrepancies Not Resolved. The Chief of Pharmacy Service acknowledged that Pharmacy Service staff who refilled the medication cart in the afternoons did not follow up on discrepancies between quantities on hand and quantities the logbook showed should have been on hand.

Recommendation 6. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) clinical staff keep the medication cart locked, (b) clinical staff log the removal of drugs from the medication cart, and (c) Pharmacy Service staff follow up on identified discrepancies when refilling the medication cart.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that an automated drug dispensing unit to replace the medication cart has been ordered, which should improve security. The target date to install the unit is June 13, 2005. In addition, clinical staff have been instructed to log the removal of drugs, and Pharmacy Service staff have been instructed to follow up on any discrepancies. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Environment of Care – Patient Care Areas Should Be Clean

Condition Needing Improvement. VA policy requires that patient care areas be clean, sanitary, and maintained to optimize infection control and patient safety. We inspected patient rooms and restrooms on four inpatient units at the Knoxville Division and three inpatient units at the Des Moines Division. Many of the patient rooms and restrooms needed better cleaning and maintenance. We observed the following conditions:

- Accumulation of debris and dust on floors along baseboards and in corners of some of the patient rooms
- Red stains (possibly blood) on vertical blinds beside a patient's bed
- Damaged, missing, incorrectly placed, stained, or moldy ceiling tiles in patient rooms and restrooms
- Soiled commodes, commode seals, floor tile, and grout
- Soiled bases on rolling patient care equipment, such as intravenous pump stands
- Accumulation of dust on air ventilation system covers

Recommendation 7. We recommended that the VISN Director ensure that the Health Care System Director requires that all patient care areas be kept clean and sanitary.

The VISN and Health Care System Directors agreed with the finding and recommendation and reported that a bimonthly inspection of all patient care areas had been implemented and corrective actions for the identified deficiencies will be completed by June 2005. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Controlled Substances Accountability – Controls Should Be Strengthened

Conditions Needing Improvement. VA medical facilities are required to maintain strong controls to ensure that all controlled substances are accounted for. To evaluate controlled substances accountability, we reviewed inspection reports for the 12-month period January–December 2004, observed unannounced inspections of selected areas where controlled substances were stored and dispensed, interviewed the Controlled Substances Coordinators for both health care system divisions, and toured pharmacy vaults at both divisions. We identified three weaknesses in controlled substances accountability.

Review of 72-Hour Inventories Not Documented. VHA policy requires Pharmacy Service to conduct and document a physical inventory of controlled substances stored in the vault at a minimum of every 72 hours. VHA policy also requires that controlled substances inspectors verify and document on the inspection reports whether the 72-hour

inventories had been completed by the Pharmacy Service staff since the last inspection. The inspection reports for the 12-month review period did not contain this documentation. The Controlled Substances Coordinators stated that the inspectors had been reviewing the 72-hour inventory records but acknowledged that they had not been told to document the results on the inspection reports.

Accountable Officer Not Appointed. VA policy requires that the Chief of Acquisition and Materiel Management Service (A&MMS), or designee, be the accountable officer responsible for witnessing the receipt and the destruction or other disposition of controlled substances. As of February 2005, the health care system had not had a Chief of A&MMS in more than a year, and no one had been appointed the accountable officer or designee in at least 5 years. According to the Chief of Pharmacy Service and the Chief of Materiel Management Section, the former Chief of A&MMS mistakenly believed that because controlled substances were delivered directly to the pharmacy and not to the warehouse, the health care system did not need an accountable officer.

Logbook for Receipt of Controlled Substances Not Signed. Patients who are issued controlled substances at discharge or transfer from the health care system must sign a logbook acknowledging receipt of the drugs. We reviewed a Knoxville Division unit's logbook and found that for the 7-month period August 2004–February 2005 it did not contain the signatures of 6 of 18 patients who had been issued controlled substances.

Recommendation 8. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) controlled substances inspectors document the results of their reviews of 72-hour inventory records, (b) an accountable officer be appointed to witness the receipt, destruction, and disposition of controlled substances, and (c) discharged or transferred patients sign the logbook acknowledging receipt of controlled substances.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that controlled substances inspectors will be required to document their review of the 72-hour inventory records. By April 28, 2005, an accountable officer was to have been appointed. Pharmacy Service and nursing staff had been instructed to require all patients to sign the logbook. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Pressure Ulcer Prevention and Management – Controls Needed To Be Improved

Conditions Needing Improvement. Health care system policy requires that a registered nurse assess each patient's skin integrity within 24 hours after admission, upon significant change in condition, and quarterly for patients in long-term care. To evaluate the health care system's controls over the prevention, identification, and management of

pressure ulcers, we reviewed a judgment sample of 10 medical records of patients who had pressure ulcers (6 inpatients and 4 outpatients) and found 4 deficiencies:

- There was no documentation of skin integrity assessments for two patients.
- There was no documentation of pressure ulcer treatment for four patients.
- Eight of the 10 records did not show that the patients and/or their caretakers had been educated on the care and prevention of pressure ulcers.
- In one record, a nurse's note incorrectly showed a pressure ulcer as stage IV (the most severe) when it was, in fact, stage I (the least severe).

Recommendation 9. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) skin integrity assessments be performed and documented as required, (b) pressure ulcer treatments be provided and documented, (c) pressure ulcer education be provided to patients and/or their caregivers and documented in the medical records, and (d) nursing staff be required to properly document pressure ulcer staging in the medical records.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that the medical records will be audited periodically to ensure compliance with documentation requirements. The target date for beginning this action is April 2005. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Information Technology Security – Contingency Plans Should Be Developed and Inactive Accounts Terminated

Conditions Needing Improvement. We reviewed health care system AIS policies and procedures to determine whether controls were adequate to protect AIS resources from unauthorized access, disclosure, modification, destruction, or misuse. We concluded that annual computer security awareness training was provided as required and that physical security for the computer rooms was adequate. However, we identified two deficiencies that needed corrective action.

Contingency Plans Not Developed. VHA policy requires medical facilities to develop and periodically test contingency plans that will reduce the impact of disruptions in services, provide critical interim processing support, and ensure that normal operations will resume as soon as possible after a disaster or other emergency. All services that are dependent on critical information systems must have contingency plans. The health care system had 17 such services. As of March 3, 2005, none of these services, including patient care services such as Primary and Specialty Care, had contingency plans.

Inactive Accounts Not Terminated. Veterans Health Information Systems and Technology Architecture (VistA) access accounts had not been terminated for some

inactive users. We reviewed VistA access for a judgment sample of 20 accounts for users who were not shown as current health care system employees in the VA payroll system as of February 8, 2005. Ten of the 20 accounts were for valid users, such as contract employees and employees of other VA facilities. However, the other 10 accounts should have been terminated because the users no longer worked at the health care system or did not have a continued need for access.

Recommendation 10. We recommended that the VISN Director ensure that the Health Care System Director takes action to: (a) develop contingency plans for required services and test the plans periodically and (b) promptly terminate VistA accounts for individuals who do not have a continued need for access.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that all required contingency plans will be completed by August 2005. In addition, procedures have been implemented to identify and terminate VistA accounts for users who do not have a continued need for access. The improvement plans are acceptable, and we will follow up on the completion of the planned actions.

Emergency Preparedness – Physical Security Should Be Strengthened and Training Provided

Conditions Needing Improvement. VA medical facilities are required to have comprehensive emergency preparedness programs in place to prevent or respond to disasters or other emergencies. In May 2004, health care system managers had identified physical security vulnerabilities during a self-assessment review. However, during our inspection, we found two deficiencies that needed management attention.

Physical Security Vulnerabilities. Mechanical equipment and outside air intakes were accessible to the public. For example, three propane storage tanks at the Knoxville Division were surrounded by only a chain link fence, leaving it vulnerable to being rammed by a fast-moving vehicle. There were no barriers, such as anti-ramming structures, to protect the entrances to critical areas, such as the Des Moines Division's main entrance and the emergency room. Pedestrian and vehicular access to the Knoxville and Des Moines Divisions was not restricted or controlled. Visitors were not easily identifiable during business hours, and visitor passes were not issued.

Specialized Emergency Response Training Not Provided. We reviewed training documentation for a judgment sample of 20 employees (10 Emergency Room, 5 Engineering Service, and 5 Police Service) and determined that none had received specialized training in emergency evacuation procedures for patients and staff. Further, 16 of these 20 employees had not received training in the selection of appropriate personal protective equipment and none of the 20 had received training in the use of this equipment for emergency situations. Practice with such equipment is critical for these 20 employees who would be the first to respond in a disaster or emergency.

Recommendation 11. We recommended that the VISN Director ensure that the Health Care System Director requires that: (a) physical security vulnerabilities be corrected and (b) specialized emergency response training be provided to employees.

The VISN and Health Care System Directors agreed with the findings and recommendations and reported that options will be explored and plans implemented to correct identified vulnerabilities. The target date for completing this action is June 2006. All specialized emergency response training will be provided to staff by September 1, 2005. The improvement plans are acceptable, and we will follow up on the completion of the planned action.

Quality Management Program – QM Data Should Be Analyzed and Recommendations Made

Condition Needing Improvement. Overall, the QM program was effective. Senior managers were supportive of QM initiatives and actively participated in QM oversight activities. However, health care system managers were not analyzing patient complaints, medication management, or blood product usage. QM data should be analyzed to assess the quality of care provided, and plans should be developed to correct identified deficiencies.

Patient Complaints. Patient complaints were collected and graphed quarterly. However, the data was not analyzed to determine trends. Although the data had been presented at the Director's staff meetings, no recommendations for improvement had been made.

Medication Management. We reviewed Pharmacy and Therapeutics Committee meeting minutes and documentation submitted to the committee, such as Medication Management Workgroup reports and pharmacy QM reports. The committee had not analyzed the data to determine trends or patterns in clinical outcomes and had not recommended corrective actions for identified problems.

Blood Product Usage. Pathology and Laboratory Service staff conducted reviews of blood product usage and reported the data to the Transfusion Workgroup. However, no quantitative analysis had been performed and no conclusions or recommendations had been made.

Recommendation 12. We recommended that the VISN Director ensure that the Health Care System Director requires that detailed data analyses be performed on patient complaints, medication management, and blood product usage and that corrective actions be taken on any identified deficiencies.

The VISN and Health Care System Directors agreed with the finding and recommendation and reported that by July 1, 2005, procedures will be implemented to ensure that detailed data analysis is performed and corrective actions taken. The

improvement plans are acceptable, and we will follow up on the completion of these planned actions.

Appendix A

VISN 23 Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 25, 2005

From: Network Director, VA Midwest Health Care Network (10N23)

Subject: Status Report – Combined Assessment Program Review, VA Central Iowa Health Care System, Des Moines, IA

To: Director, VHA Management Review Service (10B5)

1. Attached is the status report for the Office of Inspector General (OIG) Combined Assessment Program survey comments and implementation from the VA Central Iowa Health Care System, Des Moines, Iowa.

2. If you have any questions regarding this report, please contact Teresa Kumar, Quality Management Officer at (402) 484-3254.

(original signed by:)

ROBERT A. PETZEL, MD

Attachments

Appendix B

Health Care System Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 25, 2005

From: Director, Central Iowa Health Care System (636A6/00)

Subject: CAP Review Report

To: Myra Taylor, VA Office of Inspector General (52SE)

Thru: Director, VA Midwest Health Care Network (10N23)/ES/

1. Attached is the response to the OIG CAP Site Review and comments from the Network Director.

2. I appreciate the courtesy and cooperativeness displayed by you and all members of the IG Team throughout this review process.

DONALD C. COOPER

Attachment

VA Central Iowa Health System, Des Moines and Knoxville, Iowa

Response to the Office of Inspector General Combined Assessment Report

Comments and Implementation Plan

1. Service Contracts – Preaward Audits Should Be Requested and Price Reasonableness and Contractor Invoices Properly Reviewed

Recommendation 1 We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) all sole source contracts valued at $500,000 or more be submitted to the VA OIG for preaward audits, (b) cost or price analysis be performed for all sole source contracts, (c) refresher training be provided to the COTRs on responsibilities and procedures for properly certifying invoices, and (d) pain management and CBOC pharmaceuticals contractor invoices paid in FY 2005 be reviewed to ensure that all charges were correct.

Concur with recommended improvement actions

(a) All sole source contracts valued at $500,000 or more be submitted to the VA OIG for preaward audits, (b) cost or price analysis be performed for all sole source contracts

Planned Action (a) and (b): Contracting officers were reminded April 27, 2005, that as contracts come up for award to provide verification of pre-award audits for sole source contracts valued at $500,000 or more. Also, cost analysis will be performed for all sole source contracts. Target date: Complete.

(c) Refresher training be provided to the COTRs on responsibilities and procedures for properly certifying invoices

Planned Action: Refresher training will be provided by the contracting officers at both Des Moines and Knoxville to the COTRs on responsibilities and procedures for properly certifying invoices. Target completion date is June 30, 2005.

(d) Pain management and CBOC pharmaceuticals contractor invoices paid in FY 2005 be reviewed to ensure that all charges were correct.

Planned Action: Pain management and CBOC pharmaceuticals contractor invoices paid in FY 2005 will be reviewed by Contracting Officers to ensure that all charges were correct. Target date: May 31, 2005.

2. Canteen Food Service and Storage – Deficiencies Needed To Be Corrected

Recommendation 2. We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) the VCS food service and storage areas be kept clean and effectively managed, (b) the VSC kitchen door be kept locked, (c) food service and storage areas be mold-free, (d) refrigerator temperatures and thermometers be properly programmed, and (e) areas between ceiling tiles and pipes or conduits be appropriately sealed.

Concur with recommended improvement actions

(a) The VCS food service and storage areas be kept clean and effectively managed

Planned Action: Identified equipment has been replaced, cleaning supplies have been relocated to an appropriate location away from the kitchen but accessible to employees, and cleaning activities performed by VCS employees revised to include the additional items identified. Cleaning performed by EMS has been increased to twice per month. Monthly Infection Control rounds are in place, and EMS rounds have been increased to twice a month to assure that cleanliness of the area is maintained. Target date: Completed.

(b) The VSC kitchen door be kept locked

Planned Action: All VCS employees have been instructed to keep door closed and locked at all times. Target date: Completed.

(c) Food service and storage areas be mold-free

Comment: Pathology and Laboratory Service cultured four samples of the molds and determined that they were *common environmental mold*.

Planned Action: Safety staff have removed the mold. Once those factors that support mold growth are abated, Engineering Service will paint. Target date for completion: May 6, 2005.

(d) Refrigerator temperatures and thermometers be properly programmed

Planned Action: Engineering evaluated the refrigerator on April 12, 2005, to ensure the refrigerator was operating properly. Employees were instructed on the requirements for appropriate action when temperatures are outside the acceptable ranges. In addition, all Canteen employees have been instructed on how to program and calibrate and reset the electronic thermometers for refrigerators and freezers. Audits of refrigerator temperature monitoring are included in the environmental rounds. Target date: Completed.

(e) Areas between ceiling tiles and pipes or conduits be appropriately sealed

Comments: The area cited is a drop-ceiling. The area above is sealed.

Planned Action: Areas will be sealed. Target date for completion: April 28, 2005.

3. Medical Care Collections Fund – Billing and Collection Delays Should Be Reduced and Clinical Documentation Improved

Recommendation 3. We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) insurance bills be issued promptly, (b) insurance bills be pursued more aggressively, and (c) medical records include adequate clinical documentation.

Concur with recommended improvement actions

(a) Insurance bills be issued promptly

Planned Action: The coding backlog has been eliminated through a VISN coding contract. The billing department is creating bills on encounters that are 45 days and older. Target Completion Date: May 31, 2005

(**b) Insurance bills be pursued more aggressively**

Planned Action: Completed. The Accounts Receivable department is performing follow-up on high dollar claims and high volume payers on open claims between 30-90 days old.

(c) Medical records include adequate clinical documentation

Planned Action: For the past 10 months our medical records department has been working with service lines on improving clinical documentation. The clinical documentation has significantly improved during this time, decreasing the number of encounters needing improved documentation from over 250 encounters per month to 60 per month. We will continue to work with the service lines to improve the documentation. Additionally we will utilize E&M reports from our Quadramed software when training our physicians to improve their documentation. Target date: July 2005.

4. Supply Inventory Management – Excess Inventories Should Be Reduced and Controls Improved

Recommendation 4. We recommend that the VISN Director ensure that the Health Care System Director requires: (a) SPD staff to properly control stock and prevent excess medical supply inventory and keep GIP inventory records current by promptly and accurately posting inventory transactions and (b) Materiel Management Section staff to reduce excess engineering supply inventory and implement GIP for all engineering supplies.

Concur with recommended improvement actions

(a) SPD staff to properly control stock and prevent excess medical supply inventory and keep GIP inventory records current by promptly and accurately posting inventory transactions

Planned Action: SPD staff will participate in refresher GIP training that will emphasize proper stock control, prevention of excess medical supplies, and keeping inventory records current. Conversion to Med/Surg Prime Vendor will be an asset to controlling number of days of stock on hand. Target Date for completion: May 18, 2005.

Inactive Item Reports will be reviewed monthly and progress to reduce inventories documented and forwarded to Chief, Materiel Management.

Target Completion Date: December 31, 2005

(b) Materiel Management Section staff to reduce excess engineering supply inventory and implement GIP for all engineering supplies

Planned Action: The quantity of existing supplies in Engineering has resulted in products not needing replenished. Thus, GIP will not generate purchase history and usage until items are ordered. Items are being included in the GIP inventory as they are required to be replenished. The Knoxville facility is establishing a centralized storeroom. Inventory Management Specialists will be responsible for entering all items in the GIP inventory and/or reducing excess. Completion Date: December 2006.

5. Procurement of Medical and Prosthetic Supplies – Purchases Needed To Comply with VA's Purchasing Hierarchy

Recommendation 5. We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) supply products be purchased according to the purchasing hierarchy and (b) all procurement staff receive initial and refresher training on the purchasing hierarchy.

Concur with recommended improvement actions

(a) Supply products be purchased according to the purchasing hierarchy

Planned Action: An FSS source has been identified for the Tub Bench and Toilet Seat. Prosthetic Service will stock the appropriate item. (Complete)

The 14-foot cannulas and skin staplers are now being procured from the BPA by SPD. (Complete) A follow-up spot check audit will be performed within six months to ensure items are procured from correct source.

(b) All procurement staff receive initial and refresher training on the purchasing hierarchy

Planned Action: Hierarchy training will be provided to all inventory managers, supply technicians and program support clerks. Completion Date: April 29, 2005. Follow-up spot check with affected employees will be completed within three months.

6. Pharmacy Security and Drug Accountability – Controls Should Be Strengthened

Recommendation 6. We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) clinical staff keep the medication cart locked, (b) clinical staff log the removal of drugs from the medication cart, and (c) pharmacy staff follow up on identified discrepancies when refilling the medication cart.

Concur with recommended improvement actions

(a) Clinical staff keep the medication cart locked

Planned Action: The combination lock has been changed with access only to the pharmacy program manager. The lock allowing staff entry has been changed to one with a timing device that will lock automatically after a specified time interval. Police will continue to perform random checks to verify that the medication cart remains locked. A new Pyxis unit has been ordered and its installation is scheduled for no later than June 13, 2005. This will provide tighter security, inventory control, and medication accountability.

(b) Clinical staff log the removal of drugs from the medication cart

Planned Action: The clinical staff have been re-educated to log the removal of drugs from the medication carts. Pharmacy staff will review this log whenever making deliveries and notify appropriate staff and the pharmacy supervisor if discrepancies are discovered. Quarterly, a pharmacist will review usage of non-controlled medications in the medication cart. This review will be used to identify trends or patterns that may indicate potential diversion or over and under usage of inventory.

(c) Pharmacy staff follow-up on identified discrepancies when refilling the medication cart

Planned Action: Pharmacy staff have been re-educated to follow up on any discrepancies discovered when refilling the medication cart. Follow-up action will be resolved by the pharmacist or the pharmacy supervisor. Target date: Completed.

7. Environment of Care – Patient Care Areas Should Be Clean

Recommendation 7. We recommend that the VISN Director ensure that the Health Care System Director requires that all patient care areas be kept clean and sanitary.

Concur with recommended improvement actions

Planned Action:

a. **Accumulation of debris and dust on floors along baseboards and in corners of some of the patient rooms**.

Planned Action: All areas assessed and cleaned. Implemented a bi-monthly inspection on all patient care areas effective immediately. Environmental Management Service will monitor inspections monthly to determine efficiency of program. Target date: Completed.

b. **Red stains (possibly blood) on vertical blinds beside a patient's bed**.

Planned Action: Stain identified as kool-aid stain. Blind removed and replaced. Target date: Completed.

c. **Damaged, missing, incorrectly placed, stained, or moldy ceiling tiles in patient rooms and restrooms**.

Planned Action: Action to replace the tiles has been initiated. Target date for completion: June 2005.

d. **Soiled commodes, commode seals, floor tile, and grout**

Planned Action: All items identified have been cleaned and areas are to be inspected bimonthly. Target date for completion of repairs: July 2005.

e. **Soiled bases on rolling patient care equipment, such as intravenous pump stands**

Planned Action: All stock cleaned between patient uses. Items are placed into soiled utility rooms and rooms are checked twice daily by SPD for items to be cleaned. Target date: Completed.

f. **Accumulation of dust on air ventilation system covers.**

Planned Action: All ventilation system covers have been cleaned and put on a routine monthly cleaning schedule. Target date: Completed.

There will be a 90 day follow-up of all areas to ensure effectiveness of inspections and sustained compliance.

We are contacting Environmental Service Computer Tools for an on-site visit to assist in evaluating our processes and staffing levels. Target date for site visit: May 2005.

8. Controlled Substances Accountability – Controls Should Be Strengthened

Recommendation 8. We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) controlled substances inspectors document the results of their reviews of 72-hour inventory records, (b) an accountable officer be appointed to witness the receipt, destruction, and disposition of controlled substances, and (c) discharged or transferred patients sign the logbook acknowledging receipt of controlled substances.

Concur with recommended improvement actions

(a) Controlled substances inspectors document the results of their reviews of 72-hour inventory records

Planned Action: The Controlled Substance Inspectors now include a review of the 72-hour pharmacy audits in their monthly inspection of the inpatient pharmacy. The "Controlled Substances Inspection Report", has been modified to include a reminder to perform this check and a place to document that they have done so. Target date: Completed.

(b) An accountable officer be appointed to witness the receipt, destruction, and disposition of controlled substances

Planned Action: On April 28, 2005, the Chief of Materiel Management was designated the accountable officer. The

accountable officer is in the process of drafting a memo designating individuals to witness the receipt, destruction, and disposition of controlled substances. A 30-day follow-up audit will be completed by May 20, 2005.

(c) Discharged or transferred patients sign the logbook acknowledging receipt of controlled substances

Planned Action: Pharmacy and nursing require all discharged or transfer patients sign the logbook acknowledging receipt of controlled substances. The logbook will be audited monthly by the narcotic inspector to verify compliance. Target date: Completed.

9. Pressure Ulcer Prevention and Management – Controls Needed To Be Improved

Recommendation 9. We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) skin integrity assessments be performed and documented as required, (b) pressure ulcer treatments be provided and documented, (c) pressure ulcer education be provided to patients and/or their caregivers and documented in the medical record, and (d) nursing staff be required to properly document pressure ulcer staging.

Concur with recommended improvement actions

Comments: While we agree that we can improve on documentation, we would like to stress that the documentation issue is not a reflection of the effectiveness of our skin care program or the clinical outcomes. Central Iowa has an excellent skin program in place that has maintained quality patient outcomes. In 2002 we researched the use of the PUSH tool and incorporated use of the tool into practice in 2003. For the past two years we have participated in the International Pressure Ulcer Survey. Data from this international survey demonstrates our pressure ulcer incidence rate is one of the lowest in the nation. In 2004, the National (including non-VA) incidence was 7.7%; the VA incidence was 5.5%; and for VA Central Iowa the incidence rate was *0.6%.*

(a) Skin integrity assessments be performed and documented as required, (b) pressure ulcer treatments be provided and documented, (c) pressure ulcer education be provided to patients and/or their caregivers and documented in the medical

record, and (d) nursing staff be required to properly document pressure ulcer staging

Planned Action (a), (b), (c), (d): Action will focus on improving documentation of skin integrity assessments, pressure ulcer staging and treatments, and education to patients and caregivers. Auditing of medical records will be performed on an ongoing basis to ensure compliance with documentation requirements. Data will be reported to the Nursing Professional Community on a quarterly basis. Target date: July 2005.

10. Information Technology Security – Contingency Plans Should Be Developed and Inactive Accounts Terminated

Recommendation 10. We recommend that the VISN Director ensure that the Health Care System Director takes action to: (a) develop contingency plans for required services and test the plans periodically and (b) promptly terminate VistA accounts for individuals who do not have a continued need for access.

Concur with recommended improvement actions

(a) Develop contingency plans for required services and test the plans periodically

Planned Action: VA Central Iowa HCS is in the process of a Security Controls Assessment and is strengthening Contingency Plans. Contingency Plans will be completed utilizing the VISN 23 template. Target date: August 2005.

The ISO will monitor the process every 90 days to insure compliance.

(b) Promptly terminate VistA accounts for individuals who do not have a continued need for access

Planned Action: VA Central Iowa HCS ISS has terminated those accounts which are currently not active in VISTA. ISO will perform an electronic search quarterly to identify those accounts which need to be terminated. Target date: Completed.

11. Emergency Preparedness – Physical Security Should Be Strengthened and Training Provided

Recommendation 11. We recommend that the VISN Director ensure that the Health Care System Director requires that: (a) physical security vulnerabilities be corrected and (b) specialized emergency response training be provided to employees.

Concur with recommended improvement actions

(a) Correct physical security vulnerabilities

Planned Action:

1. Eliminate ground level outside air intakes on major air ventilation systems through two mechanisms: new construction will eliminate some of the vulnerable buildings, and is scheduled for completion by 2007. For vulnerable buildings that will remain in use, relocation of the problematic air intake systems is currently in the design phase, with a projected October 2005 start date and an estimated completion date of June 2006.

2. Concrete barricades are being installed around the perimeter of the propane storage tanks located on the Knoxville grounds. Target date: August 1, 2005. The feasibility and value of installing motion detector lighting throughout the area is being evaluated.

3. Anti-ramming barricades will be installed at the main (East) entrance to the main hospital by August 1, 2005.

(b) Provide specialized emergency response training

Planned Action: Complete the Emergency Preparedness training for all staff that has been established. Develop an Emergency Preparedness curriculum appropriate to those areas that require specialized training for emergency situations by June 1, 2005, and develop and execute a training calendar to monitor completion. Complete training in evacuation procedures and use of the new evacuation equipment with Nursing, EMS, and VAPD by July 1, 2005. Complete training in the selection of Personal Protective Equipment and its use in emergency situations by September 1, 2005. Utilize the *Tempo* system to fully document all aspects of emergency preparedness training in a timely fashion.

12. Quality Management Program – QM Data Should Be Analyzed and Recommendations Made

Recommendation 12. We recommend that the VISN Director ensure that the Health Care System Director requires that detailed data analyses be performed on patient complaints, medication management, and blood product usage and that corrective actions be taken on any identified deficiencies.

Concur with recommended improvement actions

(a) Detailed data analysis be performed on patient complaints and that corrective actions be taken on any identified deficiencies

Planned Action: QM staff will provide support to the Patient Advocates and the Patient Satisfaction Committee in aggregating and statistically analyzing complaint and SHEP satisfaction data. Patient Satisfaction Committee will analyze the data and identify opportunities to improve patient satisfaction. Findings and recommendations will be shared with the service lines and services for action, and at Management Team and Director's Staff Meetings on a regular basis. Target date: July 1, 2005.

(**b) Detailed data analysis be performed on medication management and that corrective actions be taken on identified deficiencies**

Comments: Aggregate root cause analysis (RCA's) on medication errors are performed systematically on a routine basis. RCA teams perform analysis and recommend corrective actions. Patient Safety staff ensure recommendations are implemented. Data is reported to the BCMA Committee and P&T Committee.

Planned Action: Quality Management is working with Pharmacy staff in data collection and analysis. Data reports will be presented to P&T Committee for analysis of trends or patterns in performance and clinical outcomes. P&T will oversee development of plans for improvement or corrective actions for identified problems. Quality Management will assist in education of P&T Committee members on data interpretation and monitoring by May 15, 2005. P&T Committee meeting minutes will reflect the data analysis, conclusions, planned actions, and follow-up beginning with May 2005 minutes.

(c) Detailed data analysis be performed on blood product usage and that corrective actions be taken on any identified deficiencies

Planned Action: Data has been consistently reported to the Blood Product Workgroup. Minutes format of the Blood Product Workgroup will be converted to reflect improved statistical analysis and conclusions and recommendations. Target date: 3rd quarter FY05. A follow-up review will be conducted 4th quarter FY05 to verify continued compliance with actions taken.

Appendix C

Monetary Benefits in Accordance with IG Act Amendments

Recommendation	Explanation of Benefit(s)	Better Use of Funds
3	Better use of funds through improved collection of MCCF insurance bills and by including adequate clinical documentation in the medical records.	$36,268
4	Better use of funds by reducing excess medical supply inventory.	13,583
	Total	$49,851

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	David Sumrall (206) 220-6654
Acknowledgments	Myra Taylor Theresa Kwiecinski Verena Briley-Hudson Wachita Haywood Gary Abe Paula Chapman Kevin Gibbons Theresa Golson Gary Humble Jennifer Roberts Annette Robinson Leslie Rogers Ron Stucky Melinda Toom Orlando Velásquez Thomas Foley

Appendix E

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