



# **Department of Veterans Affairs Office of Inspector General**

---

## **Audit of Pharmacy Service at VA Medical Center Miami, Florida**

**To Report Suspected Wrongdoing in VA Programs and Operations  
Call the OIG Hotline – (800) 488-8244**

## Contents

	Page
<b>Executive Summary</b> .....	i
<b>Introduction</b> .....	1
Purpose.....	1
Background .....	1
Scope and Methodology .....	2
<b>Results and Conclusions</b> .....	3
Pharmacy Service Needs to Implement Effective Internal Controls .....	3
VAMC Director Comments.....	10
OIG Contact and Staff Acknowledgments .....	18
Report Distribution .....	19

## Executive Summary

### Introduction

During the period April 19, 2004, to July 16, 2004, the Office of Inspector General (OIG) conducted an audit of the VA Medical Center (VAMC) Miami Pharmacy Service. The recently appointed VAMC Director requested the audit on February 3, 2004, after learning of the arrests of two employees for diversions of controlled substances (CS) at the Oakland Park Outpatient Clinic (OPOPC) Pharmacy. The VAMC Director specifically requested that the audit include the procurement, distribution, and management of pharmaceuticals,<sup>1</sup> and the destruction of expired and excess drugs.

### Results

Pharmacy Service did not have effective internal controls. The Controlled Substances Inspection Program (CSIP) was not an effective internal control to detect or prevent CS drug diversions, and Pharmacy Service did not use the Veterans Health Administration's (VHA's) prescribed inventory management practices to ensure drug accountability, or conduct mandatory annual wall-to-wall physical pharmaceutical inventories. Pharmacy Service management had no drug accountability or inventory management control programs in place for non-CS, did not ensure segregation of duties for the ordering and receiving processes, and the Accountable Officer did not witness the receipt and posting of all CS into pharmacy inventory records.

This occurred because the former Director, who was the responsible oversight official for the CSIP, had not ensured a comprehensive program was operating in accordance with VHA regulations, and the former and current Pharmacy Service management did not follow VHA regulations to effectively manage Pharmacy Service inventories. As a result, more than 750,000 CS tablets were diverted by 2 OPOPC Pharmacy Service employees over a 5-year period; Pharmacy Service CS stock-on-hand valued at about \$167,700, was in excess of VHA prescribed inventory minimum stock levels; and Pharmacy Service's lack of internal controls allowed diversions of non-CS by VAMC employees.

To correct the identified deficiencies, we recommended that the VAMC Director take action to ensure that:

- a. The VAMC has a comprehensive CSIP that is operated in accordance with VHA regulations.

---

<sup>1</sup> Pharmaceuticals include both controlled and non-controlled prescription drugs.

- b. Pharmacy Service fully implements the VHA prescribed prime vendor inventory management (PVIM) system to procure and manage pharmaceutical inventories, including conducting annual wall-to-wall physical inventories.
- c. The responsibilities for ordering and receiving pharmaceuticals are properly segregated.
- d. The Accountable Officer witnesses the receipt and posting of all CS into pharmacy inventory records.

This report was prepared under the direction of Mr. James R. Hudson, Director, and Mrs. Yolonda Johnson, Audit Manager, Atlanta Audit Operations Division.

## **Comments**

The VAMC Director agreed with the findings and recommendations and provided acceptable implementation plans. (See pages 10–17 for the full text of the Directors comments.) We will follow up on planned actions until they are completed.

For the Assistant Inspector General for Auditing

*(original signed by:)*

JAMES R. HUDSON

Director, Atlanta Audit Operations Division

## Introduction

### Purpose

The purpose of the audit was to determine whether internal controls over Pharmacy Service operations were adequate to detect or prevent drug diversions. Specifically, the audit objectives were to determine whether the CSIP was operating effectively and in accordance with VHA regulations; and inventory management controls over the procurement and distribution of pharmaceuticals and destruction of excess, expired, and unusable drugs were effective and efficient.

### Background

VAMC Miami has inpatient, outpatient, intravenous, and Spinal Cord Injury/Prosthetics pharmacies. There is also a Research Pharmacy for the investigation of drugs and an Animal Research Laboratory. VAMC Miami has community-based outpatient clinics at Oakland Park, Coral Springs, Deerfield, Hallandale, Pembroke Pines, Key Largo, Key West, and Homestead, FL. In addition, the VAMC has contracts with Homestead Air Force Base to fill prescriptions for Homestead Outpatient Clinic patients and to provide pharmacy services to the Pembroke Pines State Nursing Home.

The OPOPC has a large independent pharmacy that orders and receives its own pharmaceuticals, which are paid for from VAMC Pharmacy Service funds. During fiscal year (FY) 2004, Pharmacy Service expenditures for the VAMC and OPOPC totaled about \$18 million. As of July 16, 2004, Pharmacy Service had 96 full-time equivalent employees. The VAMC Director was appointed to that position on September 8, 2003. The Pharmacy Service Chief retired on February 27, 2004, and the Assistant Pharmacy Service Chief was designated as Acting Pharmacy Service Chief until a new Pharmacy Service Chief could be selected. The Assistant Pharmacy Service Chief was still Acting Pharmacy Service Chief at the time of our audit.

At the VAMC Director's request, a team of VAMC pharmacists from other VAMCs made a site visit from June 1-4, 2004, to review Pharmacy Service operations. We followed up on 42 of 71 recommendations made by the Pharmacy Site Visit Team report,<sup>2</sup> which excluded 29 technical and clinical issues and areas outside the scope of our audit, to determine whether corrective actions had been implemented, or the conditions still existed. Our follow-up showed that corrective actions had been implemented for 5 recommendations, 16 were in the process of being implemented or had been planned, and 21 had no action taken. The Pharmacy Site Visit Team generally identified many of the same deficiencies we found during our preliminary onsite visit during the week of May 22, 2004.

---

<sup>2</sup> *Pharmacy Site Visit, Miami VAMC*, dated June 28, 2004.

## **Scope and Methodology**

The audit covered the period July 1, 2001, through July 16, 2004. The scope of the audit was limited specifically to pharmacy CS and non-CS prescription drugs, and did not cover non-pharmaceutical items.

To accomplish the audit objectives, we reviewed VHA and local Pharmacy Service policies, handbooks, directives, and manuals; internal and external Pharmacy Service audits, surveys, and studies; OIG and Government Accountability Office audit reports; and Drug Enforcement Agency (DEA) regulations. We held discussions with top management and responsible Pharmacy Service officials; and observed and inspected pharmacy ordering, receiving, dispensing, and storage areas at both the VAMC and the OPOPC.

We obtained and analyzed computer-generated pharmaceutical databases from the OIG Austin Data Analysis Section of VAMC and OPOPC purchasing and dispensing histories from October 1, 2003, through May 25, 2004. We also reviewed CSIP inspection reports and records for the period July 2001 through April 2004. In order to test the reliability of computer-generated data for CS purchasing and dispensing, we compared the electronic purchasing data with VAMC hard-copy invoices for drug orders, and electronic dispensing records with hard copies of the VAMC's 72-hour inventory records. We found the data to be sufficiently reliable to meet the audit objectives. The audit was performed in accordance with generally accepted government auditing standards.

## **Results and Conclusions**

### **Pharmacy Service Needs to Implement Effective Internal Controls**

#### **Findings**

Our review of pharmacy operations found the following:

- The CSIP was not operating in accordance with VHA regulations.
- Inventory management and purchasing of pharmaceutical stock needed improvement.

The former Director, who was the responsible oversight official for the CSIP, had not ensured that the program was comprehensive and operating in accordance with VHA regulations, and the former and current Pharmacy Service management did not follow VHA regulations to manage Pharmacy Service inventories. As a result, more than 750,000 CS tablets were diverted by two OPOPC Pharmacy Service employees over a 5-year period; Pharmacy Service CS stock-on-hand valued at about \$167,700, was in excess of VHA prescribed inventory minimum stock levels; and Pharmacy Service's lack of internal controls allowed diversions of non-CS by VAMC employees.

#### **The CSIP Was Not Operating in Accordance With VHA Regulations**

The former VAMC Director did not establish a comprehensive program in compliance with VHA regulations to ensure safety and control of CS inventory. Deficiencies in the program included:

- A sufficient number of CS inspectors had not been appointed.
- CS inspectors were not sufficiently trained.
- CS inspections were not conducted in accordance with VHA regulations.

As a result, the CSIP did not detect major long-term CS drug diversions at the OPOPC.

VHA Handbook 1108.2 requires the medical facility Director to establish a comprehensive CSIP to ensure safety and effective control of inventory. A CSIP Coordinator (hereafter referred to as the Coordinator) and an adequate number of trained CS inspectors must be appointed by the Director in writing to perform monthly random, unannounced inspections of all areas where CS are stored. Inspectors should not be assigned to inspect the same areas 2 months consecutively.



CS inspectors are responsible for certifying the accuracy of CS inventory records, including all pharmacy vaults, automated dispensing machines (ADMs<sup>3</sup>), and drugs held for destruction; ensuring that CS purchases are properly recorded into pharmacy inventory records when received; ensuring that any drug stock removed from inventory for destruction since the last inspection is properly logged into the record of drugs awaiting destruction; randomly verifying that there are valid prescriptions or inpatient orders for Schedule II CS; and ensuring that 72-hour inventories of CS have been completed since the last inspection.

Sufficient Number of Inspectors Had Not Been Appointed. There were an insufficient number of inspectors to ensure that CS inspections were performed in accordance with VHA regulations. Although VHA regulations require an adequate number of inspectors to ensure a comprehensive inspection program, the regulations contain no prescribed method to calculate the number of inspectors that would be considered adequate. At the time of our audit, the VAMC had 26 inspectors who were appointed on an annual basis.

Since inspectors had to complete inspections in 1 day, they generally only reconciled the quantity of CS stock-on-hand to the inventory records. They did not complete all required inspection activities, such as ensuring that CS purchases were recorded into inventory when received, ensuring that CS scheduled for destruction were logged into the record of drugs awaiting destruction, and randomly verifying there were valid prescriptions or inpatient orders for Schedule II CS.

This occurred because the former Director did not appoint an adequate number of inspectors, as required. Instead, local practice was for the Coordinator to send annual requests to VAMC service chiefs to voluntarily assign employees to be CSIP inspectors. The Coordinator stated that while some service chiefs supported the program, many were unwilling to assign this collateral duty to a sufficient number of employees to adequately support the program. As a result, inspectors were assigned to inspect the same areas for 2 or more consecutive months, which is contrary to VHA regulations.

Not All Inspectors Received Annual Training. VHA regulations require that inspectors complete annual CS orientation and training. The two CSIP inspectors at the OPOPC performed inspections for over 18 months before they received the required inspection training in March 2004.

Monthly CS Inspections Were Not Random and Unannounced. In our 2001 Combined Assessment Program review of the VAMC,<sup>4</sup> we reported that local written CS inspection instructions improperly directed inspectors to contact designated Pharmacy Service employees to pre-schedule their inspections during the second and third weeks of the

---

<sup>3</sup> The ADM is an automated dispensing system for solid oral drugs that fills and labels most non-CS and Schedule II and IV prescriptions.

<sup>4</sup> *Combined Assessment Program Review VA Medical Center Miami, Florida*, Report No. 00-02974-35, January 31, 2001.

jmonth, rather than making them random and unannounced. At the time of our audit, we found that the CSIP had not changed this practice, but was still using the same guidelines from 2001. Limiting monthly CS inspections establishes a predictable pattern and reduces their effectiveness in detecting and preventing diversions.

Not All CS Storage Sites Were Included in the Monthly Inspections. Inspectors never counted CS in the Outpatient Pharmacy ADM as required. From October 1, 2003, through May 25, 2004, the Outpatient Pharmacy transferred more than 355,250 doses of CS costing over \$102,600 to the ADM. After the CS was placed into the ADM locked area, there was no further accountability for these drugs.

Other Deficiencies in the CSIP Inspection Process. We also identified additional deficiencies in the CS inspection process, as discussed below:

- Inspectors did not ensure that all CS received had been placed into inventory by comparing the monthly prime vendor invoice summary report and all invoices against the pharmacy drug receipt history report. This review could have quickly detected the major, long-term CS diversions at the OPOPC.
- Inspectors did not ensure that drug stock removed from inventory for destruction was properly logged into the record of drugs awaiting destruction. DEA and VHA regulations require strict accountability for all expired or excess CS. These drugs are to be delivered to the Inpatient Pharmacy vault technician to log them into the drug destruction record and hold them for disposition. The quarterly disposition of CS must be witnessed and attested to by designated VAMC officials, and DEA must be provided a listing of the drugs destroyed.

We found that Outpatient Pharmacy staff were storing excess and expired drugs from the ADM, including CS, in a large open plastic container in an unsecured area in the pharmacy. The container was placed on the floor near the ADM so that it was readily accessible for use by ADM technicians, which greatly increased the likelihood of diversion. When the containers became full the excess and expired drugs were destroyed in the VAMC incinerator. CSIP inspectors should have identified this improper practice soon after the ADM was installed.

The Outpatient Pharmacy Supervisor took immediate corrective action to ensure that CS drugs from the ADM that were slated for destruction were placed in labeled, sealed, plastic bags and were locked in the vault in compliance with DEA and VHA regulations.

- Inspectors did not randomly verify that there were valid electronic or hard copy prescriptions or doctor's orders for inpatients for Schedule II prescriptions that had been dispensed. In September 2002, a newly formed Quality Assurance Review Team began conducting some of the CSIP inspection duties, such as randomly verifying that a doctor had ordered Schedule II CS that had been dispensed, and

determining whether CS purchases were recorded into inventory. However, these reviews had not been performed since December 2003 due to a lack of inspectors.

- Monthly inspections did not verify that 72-hour inventories were completed. Although the ADM Lead Technician was conducting 72-hour inventories of the CS in the ADM, any identified shortages or overages could not be reconciled because of the improper disposal practices for expired or excess CS from the ADM. Additionally, the Supervisory Pharmacist at the OPOPC did not conduct 72-hour inventories of CS drugs slated for destruction stored in the vault. These deficiencies should have been identified during the monthly inspections.

The Pharmacy Site Visit Team subsequently identified these same conditions after our initial site visit during the week of May 22, 2004. They recommended that more inspectors be assigned and their appointments extended to 2 years, and the CSIP training program be evaluated to ensure it meets VHA requirements and supports the success of the program.

In discussions with the Director, he stated that he would ensure there were an adequate number of trained inspectors for an effective CSIP by coordinating the selection of the inspectors with the Coordinator; and notifying the inspectors and their respective service chiefs of their assignments in writing. He also stated that he intended to make the Coordinator position, which had historically been a collateral duty, a full-time position to ensure an effective CSIP.

### **Pharmacy Service Management Did Not Follow VHA Regulations to Manage Its Inventories**

Pharmacy Service management needed to implement or strengthen internal controls to ensure that pharmaceuticals are effectively managed. We identified the following deficiencies in Pharmacy Service that needed improvement:

- VHA's prescribed PVIM system was not used to establish reorder points to limit stock-on-hand.
- Mandatory annual wall-to-wall physical inventories of pharmaceuticals were not conducted.
- No drug accountability or inventory management control programs were in place for non-CS drugs.
- There was a lack of segregation of duties for individuals responsible for ordering and receiving pharmaceuticals.

- The Accountable Officer did not witness the receipt and posting of all CS into inventory records.

These conditions occurred because both the former and current Pharmacy Service management did not follow VHA regulations to manage Pharmacy Service operations. As a result, Pharmacy Service CS stock-on-hand valued at about \$167,700 was in excess of VHA prescribed inventory minimum stock levels, and the lack of internal controls over non-CS allowed diversions by VAMC Miami Pharmacy Service employees.

VHA Handbook 1761.2 requires the use of the PVIM system to assist medical facilities in minimizing the total replenishment cost of inventory by calculating reorder points and minimum inventory stock levels. In order to establish and maintain accurate inventory balances to effectively use the PVIM system, Pharmacy Services are required to perform annual wall-to-wall physical inventories of all pharmaceuticals.

The PVIM System Was Not Used to Manage Inventory Stock Levels. Although Pharmacy Service was ordering pharmaceuticals using the PVIM system, Pharmacy Service management had not implemented the inventory management segment of the system to establish reorder points to maintain minimum inventory stock levels.

In order to quantify whether there were excess CS levels at VAMC Miami and the OPOPC, we used the prescribed PVIM methodology to analyze records of CS purchased and dispensed from October 1, 2003, through May 25, 2004. As of May 25, 2004, VAMC Miami and the OPOPC had combined inventories of 734,246 doses of CS that cost \$207,967. Our review and analysis of CS purchases and usage showed CS stock-on-hand of 541,651 doses (74 percent of 734,246) valued at \$167,671 that was in excess of VHA inventory minimum stock levels, as shown below:

**Excess CS Stock-On-Hand as of May 25, 2004**

<b>Pharmacy Doses</b>	<b>Ending Inventory</b>	<b>Inventory Value</b>	<b>Excess Stock</b>	<b>Excess Stock Value</b>	<b>Percent of Excess Doses</b>
Inpatient	364,597	\$115,761	239,691	\$97,555	66
Outpatient	279,477	68,889	227,123	51,712	81
OPOPC	90,172	23,317	74,837	18,404	84
<b>Totals</b>	<b>734,246</b>	<b>\$207,967</b>	<b>541,651</b>	<b>\$167,671</b>	<b>74</b>

The Pharmacy Site Visit Team also reported that there was too much CS on hand, and recommended that a systematic and organized process of ordering CS inventory should be developed to maintain limited stock-on-hand based on actual usage and utilization.

We were unable to quantify potential excess non-CS stock-on-hand because Pharmacy Service management did not maintain inventory records for these drugs. There were no drug accountability or inventory management control programs in place for non-CS, and no oversight provided for the entire inventory process. The Pharmacy Site Visit Team identified similar conditions.

When we discussed these deficiencies with the VAMC Director, he stated that the PVIM system would be implemented to establish re-order points to limit stock-on-hand, and that the mandated inventories would be performed.

Annual Wall-to-Wall Physical Inventories Were Not Conducted. Pharmacy Service had not performed the mandatory annual wall-to-wall physical inventories of all pharmaceuticals. According to the Acting Pharmacy Service Chief, he could find no documentation that the former Pharmacy Service Chief had ever conducted the mandatory annual wall-to-wall physical inventories, and he was personally unaware that the inventories were required. The Pharmacy Site Visit Team also identified this deficiency.

Lack of Segregation of Duties. Former and current Pharmacy Service management had not implemented adequate procedures to ensure responsibilities for the ordering and receiving processes for CS were properly segregated. At both the VAMC and OPOPC, two employees shared responsibilities as primary and alternate for each other for ordering and receiving all pharmaceuticals from the prime vendor.

Because an individual could both order and receive pharmaceuticals, there was no control to prevent them from destroying the invoices and diverting drugs without recording them into pharmacy inventory records, resulting in diversions going undetected. After we brought this to the attention of the Acting Pharmacy Service Chief, he took immediate action to designate appropriate primaries and alternates for the ordering and receiving responsibilities to ensure proper segregation of duties. The Director stated that he would ensure proper segregation of duties was implemented for the ordering and receiving processes.

Receipt and Posting of All CS Into Inventory Records Was Not Witnessed by the Accountable Officer. The Accountable Officer witnessed the receipt and posting of Schedule II CS into inventory, but not other CS, as required by DEA and VHA regulations. This occurred because Pharmacy Service local policy only required the presence of the Accountable Officer for Schedule II drugs. At both the VAMC and the OPOPC, only Schedule II drugs were delivered directly to the Pharmacy Service vaults, where they were opened and counted by the vault pharmacists, with the designated Accountable Officer present to witness the receipt and posting of the drugs into inventory. All other CS were opened and delivered to the vaults by the receiving technician.

The Acting Pharmacy Service Chief stated that he was unaware that VHA regulations required the Accountable Officer to witness the receipt and posting of all CS drugs into inventory records. After providing him a copy of the regulation, he took immediate action to ensure all CS were delivered directly to the vaults, and that the Accountable Officer witnessed the receipt and posting into inventory records of all CS. The Director also said he would ensure that appropriate action was taken to ensure that the Accountable Officer witnessed the receipt and posting of all CS into inventory records.

**Recommended Improvement Action 1.** We recommended that the VAMC Director should take action to ensure that:

- a. The VAMC has a comprehensive CSIP that is operated in accordance with VHA regulations.
- b. Pharmacy Service fully implements the VHA prescribed PVIM system to procure and manage pharmaceutical inventories, including conducting annual wall-to-wall physical inventories.
- c. The responsibilities for ordering and receiving pharmaceuticals are properly segregated.
- d. The Accountable Officer witnesses the receipt and posting of all CS into pharmacy inventory records.

### **Medical Center Director's Comments**

The Medical Center Director agreed with the findings and recommendations. Medical center managers provided plans to improve the CSIP and the PVIM system, conducted a wall-to-wall physical inventory, segregated staff responsibilities for ordering and receiving pharmaceuticals, and required the Accountable Officer witness the receipt and posting of CS into inventory.

### **Assistant Inspectors General Comments**

The Medical Center Director agreed with the findings and recommendations, and provided acceptable improvement plans. We will follow up on planned actions until they are complete.

## VAMC Director Comments

**Department of  
Veterans Affairs**

### Memorandum

**Date:** August 4, 2005

**From:** VAMC Director, VA Medical Center Miami, Florida

**Subject:** **Audit of Pharmacy Service at VA Medical Center  
Miami, Florida**

**To:** Assistant Inspector General for Auditing (52)

The Miami Veterans Affairs Medical Center (546) thanks you for your visit.

Here is our response to the recommendations:

#### Recommendations/Findings:

A. The CISP was not operating in accordance with VHA regulations.

Concur

#### Action Plan

1. A total of 17 Controlled Substance (CS) Inspectors are currently performing CS inspections for the Miami VAMC.

Target Date: Completed May 2005

2. Controlled Substance Coordinator (CSC) was assigned full-time.

Target Date: Completed May 2005

3. Ten additional CS Inspectors will be assigned to serve as alternate CS Inspectors.

Target Date: December 2005

4. Three inspectors appointed for the Oakland Park Outpatient Clinic (OPOPC).

Target Date: Completed December 2004

5. Current appointments are one-year appointments. The need for two-year appointments will be considered for the next group of inspectors.

Target Date: April 2006

Recommendations/Findings:

- B. CS Inspectors were not sufficiently trained.

Concur

Action Plan:

1. All of the newly appointed CS Inspectors for Miami VAMC received CS orientation and training prior to their first inspection. This consisted of a lecture with provided written handouts, hands-on audit-trail training, and completion of the on-line Employee Education System Controlled Substance/Drug Diversion Inspection Certification Program.

Target Date: Completed May 2005

2. The CS Inspectors at OPOPC were provided refresher training.

Target Date: Completed June 2005

Recommendations/Findings:

- C. CS Inspectors were not conducted in accordance with VHA Regulations.

Concur

Action Plan:

1. A full-time CSC was appointed in May 2005. The new CSC reviewed the CSIP at this time to ensure compliance with VHA Handbooks 1108.1 and 1108.2.



Target Date: Completed May 2005

Recommendations/Findings:

D. Monthly CS Inspections were not random and unannounced.

Concur

Action Plan:

1. Current practice consists of random and unannounced monthly CS Inspections. They are not scheduled or predictable.

Target Date: Completed May 2005

Recommendations/Findings:

E. Not all CS Storage Sites were included in the monthly inspections. Inspectors never counted CS in the outpatient pharmacy ADM.

Concur

Action Plan:

1. All CS Storage Sites are included in monthly inspections.

Target Date: Completed May 2005

2. CS are not currently stocked in the outpatient pharmacy ADM (Optifill).

Target Date: Completed August 2004

F. Other deficiencies in the CSIP Inspection Process:

Recommendations/Findings:

(1) Inspectors did not ensure that all CS received had been placed into inventory.

Concur

Action Plan:

(a) As part of the current CS inspection process for the inpatient vault and OPOPC vault, inspectors review each Controlled Substance line item on the copies of all invoices for a matching increase o the master vault perpetual inventory.

Target Date: Completed May 2005

Recommendations/Findings:

(2) Inspectors did not ensure that drug stock removed from inventory for destruction was properly logged into the record of drugs awaiting destruction. Outpatient pharmacy staff was storing excess and expired drugs from the ADM, including CS, in a large open plastic container in an unsecured area in the pharmacy.

Concur

Action Plan:

(a) As part of the current monthly inspection process, the inspectors for the inpatient vault and the OPOPC vault ensure that expired drugs have been quarantined for disposition. The expired drugs are inventoried by the inspector. Audit trails for ten randomly selected drugs for destruction are also reviewed as part of the inspections process. Excess or expired CS in the outpatient pharmacy are no longer stored in an open container in an unsecured area.

Target Date: Completed May 2005

Recommendations/Findings:

(3) Inspectors did not randomly verify that there were valid electronic or hard copy prescriptions or doctor's orders for inpatients for Schedule II prescriptions that had been dispensed.

Concur

Action Plan:

(a) As part of the current monthly inspection process, inspectors perform audit-trails for five randomly selected

dispensing activities on each inpatient unit. Audit-trail confirmed that there is a valid physician order and that the nurse documented the administration of the CS. On a unit with less than five dispensing activities, at least 2 orders are reviewed if possible by the inspector.

Target Date: Completed May 2005

Recommendations/Findings:

(4) Monthly inspections did not verify that 72-hour inventories were completed.

Concur

Action Plan:

As part of the current monthly inspection process, the inspectors verify that the 72-hour inventories were completed for pharmacy vaults. Any deficiencies are noted and reported to the Chief, Pharmacy Service and to the Director.

Target Date: Completed May 2005

Recommendations/Findings:

G. VHA's Prescribed PVIM system was not used to establish recorder points to limit stock-on-hand.

Concur

Action Plan:

1. Currently Pharmacy procurement is still depleting the excess inventory.

Target Date: September 2005

2. Meeting with McKesson (Prime Vendor) to plan implementation of a comprehensive PVIM.

Target Date: Completed August 2, 2005

3. Separate Inpatient and Outpatient into two separate accounts for Prime Vendor.

Target Date: August 19, 2005

4. Establish stock and par levels in accordance with VHA Handbook 1761.2.

Target Date: January 2006

5. Bar Code all inventory with stock and par level.

Target Date: January 2006

6. Publish Policy & Procedures for PVIM.

Target Date: January 2006

7. Staff training on PVIM Policy & Procedures.

Target Date: January 2006

Recommendations/Findings:

H. Mandatory annual wall-to-wall physical inventories of pharmaceuticals were not conducted.

Concur

Action Plan:

1. Wall-to-wall inventory completed.

Target Date: Completed April 11, 2005

2. Submitted to PBM.

Target Date: Completed May 2005

Recommendations/Findings:

I. No drug accountability or inventory management control programs were in place for non-CS drugs.

Concur

Action Plan:

1. Drug accountability software has been installed. The system is currently being tested.

Target Date: Ongoing

2. Staff training.

Target Date: September 2005

3. Go Live.

Target Date: October 2005

Recommendations/Findings:

J. There was a lack of segregation of duties for individuals responsible for ordering and receiving pharmaceuticals.

Concur

Action Plan:

1. Identified staff and separated duties to ensure the same person that ordered would not receive order.

Target Date: Completed June 2005

2. Policy - SOP in progress.

Target Date: October 2005

3. Inservice for staff on Policy & Procedure.

Target Date: October 2005

Recommendations/Findings

K. The Accountable Officer did not witness the receipt and posting of all CS into inventory records.

Concur

Action Plan:

1. Accountable Officer witnesses receipt and posting of all CS into inventory records.

Target Date: Completed June 2004

2. MOU between Pharmacy and A&MM in progress.

Target Date: October 2005.

*(original signed by:)*

Stephen M. Lucas, Medical Center Director

## **OIG Contact and Staff Acknowledgments**

---

OIG Contact	James R. Hudson, Director, Atlanta Audit Operations Division (404) 929-5921
-------------	--

---

Acknowledgments	Yolonda Johnson, Audit Manager Ann Batson, Team Leader Leon Roberts, Staff Auditor Cheri Preston, Staff Auditor
-----------------	--

## Report Distribution

### **VA Distribution**

Office of the Secretary  
Veterans Health Administration  
Assistant Secretaries  
General Counsel  
Director, VA Medical Center Miami, Florida (546/00)

### **Non-VA Distribution**

House Committee on Veterans' Affairs  
House Appropriations Subcommittee on Military Quality of Life and Veterans Affairs  
House Committee on Government Reform  
Senate Committee on Veterans' Affairs  
Senate Appropriations Subcommittee on Military Construction and Veterans Affairs  
Senate Committee on Governmental Affairs  
National Veterans Service Organizations  
Government Accountability Office  
Office of Management and Budget  
U.S. Senate: Bob Graham, Bill Nelson  
U.S. House of Representatives: Lincoln Diaz-Balart, Mario Diaz-Balart, Alcee Hastings,  
Kendrick Meek, Illena Ros-Lehtinen, Debbie Wasserman Schultz, Clay Shaw,  
Robert Wexler

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