Department of Veterans Affairs
Office of Inspector General

Combined Assessment Program Review of the VA Medical Center Fayetteville, North Carolina

Report No. 05-02813-40 **December 12, 2005**

VA Office of Inspector General
Washington, DC 20420

Office of Inspector General

Combined Assessment Program Reviews

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

- Evaluate how well VA facilities are accomplishing their missions of providing veterans convenient access to high quality medical and benefits services.
- Determine if management controls ensure compliance with regulations and VA policies, assist management in achieving program goals, and minimize vulnerability to fraud, waste, and abuse.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the **requirement** to refer suspected **criminal activity** to the OIG.

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

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Executive Summary

Introduction

During the week of August 15-19, 2005, the Office of Inspector General (OIG) conducted a Combined Assessment Program (CAP) review of the VA Medical Center (the medical center), Fayetteville, North Carolina. 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 provided five fraud and integrity awareness briefings to 736 employees. The medical center is under the jurisdiction of Veterans Integrated Service Network (VISN) 6.

Results of Review

We identified the process for locating missing patients as an organizational strength.

The CAP review focused on 11 areas. The medical center complied with selected standards in the following six areas:

- Contract Award and Administration
- Information Technology Security
- Medical Care Collections Fund
- Part-Time Physician Time and Attendance
- Quality Management
- Radiology and Laboratory Timeliness

We identified four areas that needed management attention. To improve operations, the following recommendations were made:

- Improve controlled substances inspection program.
- Improve controls over supply inventory management.
- Conduct reviews of government purchase cards.
- Improve safety and cleanliness of patient care areas.

We reviewed colorectal cancer management and made no recommendations.

This report was prepared under the direction of Ms. Victoria Coates, Director, and Ms. Christa Sisterhen, Associate Director and CAP Review Coordinator, Office of Healthcare Inspections.

VISN and Medical Center Directors' Comments

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable implementation plans. (See pages 12-21 for the full text of the Directors' comments.) We will follow up on planned actions until they are completed.

(original signed by:)
JON A. WOODITCH
Deputy Inspector General

Introduction

Medical Center Profile

Organization. The medical center provides a broad range of inpatient and outpatient health care services. Care is also provided at two community-based outpatient clinics located in Jacksonville and Wilmington, North Carolina. The medical center is part of VISN 6 and serves a veteran population of about 155,000 in a primary service area that includes 21 counties in northeastern South Carolina to southeastern North Carolina.

Programs. The medical center provides medical, surgical, mental health, geriatric, rehabilitation, and dental services. The medical center has 90 hospital beds and 69 nursing home beds. The medical center also has sharing agreements with Womack Army Medical Center, Fort Bragg, North Carolina.

Affiliations. The medical center is affiliated with Womack Army Medical Center, East Carolina University, and University of North Carolina at Chapel Hill.

Resources. In fiscal year (FY) 2004, medical care expenditures totaled $115 million. The FY 2005 medical care budget is $116.2 million. FY 2004 staffing totaled 878 full-time equivalent employees, including 51 physicians and 270 nurses.

Workload. In FY 2004, the medical center treated 37,771 unique patients. The medical center provided 18,762 inpatient days of care in the hospital and 24,263 inpatient days of care in the Nursing Home Care Unit. The inpatient care workload totaled 3,472 discharges, and the average daily census, including nursing home patients, was 117. The outpatient workload was 322,185 visits.

Objectives and Scope of the CAP Review

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

- Conduct recurring evaluations of selected health care facility and regional office operations focusing on patient care, quality management, benefits, and financial and administrative controls.
- Provide fraud and integrity awareness training to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope. We reviewed selected clinical, financial, and administrative activities to evaluate the effectiveness of patient care administration, QM, and general management controls. Patient care administration is the process of planning and delivering patient care. QM is

the process of monitoring the quality of patient care to identify and correct harmful or potentially harmful practices or conditions. Management controls are the policies, procedures, and information systems used to safeguard assets, prevent errors and fraud, and ensure that organizational goals are met. We also followed up on the recommendations of our previous CAP review of the medical center *(Combined Assessment Program Review of VA Medical Center Fayetteville, North Carolina*, Report No. 01-02940-166, September 20, 2002).

The review covered facility operations for FY 2004 and FY 2005 to date, and was done in accordance with OIG standard operating procedures for CAP reviews. In performing the review, we inspected work areas; interviewed managers, employees, and patients; and reviewed clinical, financial, and administrative records. The review covered selected aspects of the following:

Colorectal Cancer Management	Part-Time Physician Time and Attendance
Contract Award and Administration	Prescription Drugs
Environment of Care	Quality Management
Government Purchase Card Program	Radiology and Laboratory Timeliness
Information Technology Security	Supply Inventory Management
Medical Care Collections Fund	

As part of the review, we used questionnaires and interviewed 34 patients to survey their satisfaction with the timeliness of services and quality of care. The survey results were provided to medical center management.

During this review, we also presented 5 fraud and integrity awareness briefings to 736 medical center 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. We identified an organizational strength regarding the rapid location of missing patients. Areas needing improvement are discussed in the Opportunities for Improvement section (pages 4–9). Findings from the colorectal cancer management review are discussed in the Additional Area of Review section (page 10). 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. For other areas not discussed in the Opportunities for Improvement section, there were no reportable conditions.

Results of Review

Organizational Strength

Missing Patients Can Be Rapidly Located

After evaluation of a missing patient incident, medical center managers improved processes to identify high-risk patients and search for missing patients. Medical center managers modified the assessment tool used to determine patient potential for wandering and/or elopement and provided specially colored blue pajamas to inpatients identified as high-risk. Aggregate data of missing patient searches indicated it was taking 1 hour, on average, to locate a missing patient. The medical center took these additional actions to improve the search process:

- Purchased Project Lifesaver to electronically track and locate missing patients. Project Lifesaver relies on radio technology and includes mobile locater tracking systems and transmitters that emit a tracking signal for a 1-mile ground radius and a 10-mile air radius. Patients at risk for wandering and elopement wear Project Lifesaver transmitters.
- Performed mock search drills utilizing a mannequin "patient" wearing a Project Lifesaver transmitter and the special blue pajamas to ensure staff competence in search procedures.

Data collected from each of the two quarterly mock drills conducted since the March 31, 2005, implementation of these new processes showed an average of 26 minutes to locate the "patient." The facility has enhanced patient safety through implementation of these identification and search procedures.

Opportunities for Improvement

Prescription Drugs – Controlled Substances Inspection Program Needed Improvement

Condition Needing Improvement. The medical center's controlled substances (CS) inspection program needed improvement. All areas were not inspected monthly as required by VHA policy, and inspection procedures were not adequate.

The CS Coordinator did not ensure that all areas containing controlled substances were inspected monthly. For the period July 2004 through June 2005, only 332 (84 percent) of 393 areas containing controlled substances were inspected. This occurred because Pharmacy Service management did not provide the CS Coordinator a complete list of the areas with controlled substances.

During our observation of the main pharmacy vault inspection, the CS inspector official did not:

- Require the pharmacist to conduct a physical count of the contents of open containers.
- Verify the pharmacist's physical count of unopened containers on the shelves.
- Require the pharmacist to use a volumetric cylinder to measure liquids in open containers.
- Review drugs for expiration dates.

During our observation of two inpatient units' inspections, the CS inspector officials did not:

- Verify that nursing staff conducted counts of all controlled substances at every shift change.
- Verify that nursing staff appropriately documented transfers of controlled substances between units.

These deficiencies occurred because the CS Coordinator did not periodically observe the CS inspectors to determine if they were conducting the inspections appropriately, as required by VHA policy.

Recommended Improvement Action(s) 1. The VISN Director should ensure that the Medical Center Director requires that (a) all areas containing controlled substances be inspected and (b) the CS Coordinator periodically observe the inspectors to ensure that proper procedures are followed.

The VISN Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that the Chief of Pharmacy or designee will notify the Controlled Substance Coordinator when there are additions or deletions to the controlled substances locations. The Controlled Substance Coordinator will periodically observe inspectors for compliance with the inspection process and establish records of observation. We will follow up on the planned actions until they are completed.

Supply Inventory Management – Inventory Controls Needed Improvement

Condition Needing Improvement. Acquisition and Materiel Management Service (A&MMS) staff did not effectively use the Generic Inventory Package (GIP) system to manage inventory levels for some inventory control points (ICPs). GIP inventory records did not accurately reflect inventory balances for five of the seven medical center's ICPs including Engineering Service, Dental Service, Environmental Management Service (EMS), Laboratory Service, and Imaging Service. The remaining two ICPs (Supply Distribution and Processing (SPD) Section and the Supply Warehouse) met VA's minimum acceptable inventory accuracy rate of 90 percent.

The medical center's 7 ICPs had 1,612 inventory line items valued at about $218,000, as of July 31, 2005. We reviewed a sample of 100 stock items valued at about $83,600 from the ICPs and found that inventory records were not accurate for 32 items (32 percent). Balances for 22 items were overstated by about $5,100 (less stock on hand than recorded in GIP) and balances for 10 items were understated by about $2,500 (more stock on hand than recorded in GIP), a net difference of about $2,600. The results of the counts were as follows:

ICP	Items Counted	Number of Incorrect Balances	Accuracy Rate	GIP Inventory Value	Adjusted Value	Variance
Engineering Service	25	11	56%	$15,633	$14,888	-$ 745
SPD Section	20	2	90%	8,256	8,195	-61
Dental Service	15	5	67%	2,375	2,779	404
EMS	10	9	10%	4,445	2,560	-1,885
Laboratory Service	10	3	70%	35,722	35,454	-268
Imaging Service	10	2	80%	5,721	5,679	-42
Supply Warehouse	10	0	100%	11,462	11,462	0
Total	**100**	**32**	**68%**	**$83,614**	**$81,017**	**-$2,597**

These deficiencies occurred because the ICPs' staffs did not post receipts and disbursements timely, some bar coding labels were missing, and nomenclature and units of issue for some items needed to be updated in GIP.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the Medical Center Director requires that (a) GIP records contain accurate inventory balances, (b) ICP stock usage is entered into GIP timely, (c) missing bar code labels are replaced, and (d) GIP records contain accurate nomenclature and units of issue information.

The VISN Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that wall-to-wall inventories will be held on a monthly basis to ensure records remain accurate; balances for the seven identified inventory control points were adjusted to correct for over/under stated dollar amounts; usage data will be entered into GIP timely; missing barcode labels were replaced; and each inventory control point was reviewed and correct information was entered for nomenclature and units of issue. We will follow up on the planned actions until they are completed.

Government Purchase Card Program – Controls Needed Improvement

Condition Needing Improvement. The medical center needed to improve controls over the Government Purchase Card Program. During the 21-month period ending June 30, 2005, the medical center's 42 cardholders completed 35,343 transactions totaling about $11.8 million. The following deficiencies in the Government Purchase Card Program needed improvement:

Unused Purchase Card Accounts Needed to be Cancelled. Ten of the medical center's 98 purchase card accounts were no longer needed and should be cancelled. The Purchase Card Coordinator (PCC) did not cancel 10 purchase card accounts no longer needed by 5 employees. While the PCC removed the purchase card accounts from the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) system, the purchase card accounts remained open in the Citibank proprietary system because the PCC took no action to close the accounts with Citibank. As of August 17, 2005, the status of the 10 accounts was:

- Three accounts had not been used since they were opened in June 2004. The PCC is discussing the need for these cards with the cardholders' supervisor.
- Three accounts, assigned to an employee who separated from the VA on May 27, 2005, were cancelled during the CAP review.
- Four accounts, assigned to employees of VAMC Beckley to assist VAMC Fayetteville in purchasing prosthetic items, were no longer needed and cancelled during the CAP review.

VHA policy requires that the Coordinator performs daily account maintenance in the Citibank proprietary system and in IFCAP, including setting up, modifying, and cancelling cardholder purchase card accounts.

Quarterly Reviews Needed to be Conducted. During the first and second quarter of FY 2005, only 11 and 17 of the 98 active accounts were reviewed, respectively. None of the active accounts had been reviewed during the third quarter or the fourth quarter as of August 19, 2005. Prior to June 2005, VHA policy required that quarterly reviews be conducted of all cardholder accounts. VHA issued new policy in June 2005, requiring that 25 percent of all cardholder accounts are reviewed each quarter. The Coordinator was not aware of the requirement that 25 percent of accounts be reviewed.

Recommended Improvement Action(s) 3. The VISN Director should ensure that the Medical Center Director requires that (a) unused accounts be terminated in both IFCAP and Citibank's proprietary system and (b) twenty-five percent of all cardholder accounts are reviewed quarterly.

The VISN Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that unused accounts will be terminated in both IFCAP and Citibank's proprietary system and a system is now in place to review 100 percent of all cardholder accounts each fiscal year. We will follow up on the planned actions until they are completed.

Environment of Care – Safety and Cleanliness of Patient Care Areas Needed Improvement

Condition Needing Improvement. VA policy requires that patient care areas be clean, sanitary, and maintained to optimize patient safety and infection control. We inspected eight patient care areas and found the following conditions requiring management attention:

Fire Safety Door. The fire safety door to unit 2C did not close properly. National Fire Prevention Association Life Safety Code and Joint Commission on Accreditation of Healthcare Organizations (JCAHO) environment of care standards require that fire safety doors close securely when released with alarm activation. This deficiency was identified during the April 2005 Annual Workplace Evaluation (AWE) and reported as corrected in May 2005 by Engineering Service. During our inspection, we found the condition still existed. There is increased potential for patient, staff, or visitor injury during a fire emergency if fire safety doors do not close properly.

Emergency Medical Gas Shut Off Valves. Access to the emergency medical gas shut off valves in the Post Anesthesia Care Unit (PACU) was obstructed due to storage of medical equipment in the alcove where the shut off valves were located. JCAHO environment of

care standards require that emergency medical gas shut off valves be accessible. Patient safety could be compromised due to delays in accessing shut off valves.

Room Number Signage. We found patient room number signs absent, misplaced, or incorrectly designated on the units we inspected. Incorrect room number signage could delay location of a patient room during an emergency. Medical center managers acknowledged that signage throughout the facility was deficient and informed us they had an ongoing project to correct this condition. We recommended they expedite correction in patient care areas.

Waste Receptacles. The waste receptacles in seven of the inspected areas were not clean. Interior surfaces of waste receptacles, including lids, were dirty; some had evidence of developing mold. JCAHO requires medical centers to provide a clean and infection-free environment. The presence of mold and unsanitary conditions in patient care areas increases the possibility of hospital-acquired infections. We discussed this concern with medical center managers who told us they had ordered new waste receptacles and developed a protocol for routine cleaning.

Moisture and Mold. We found degrading plaster, mold, and mildew on interior walls in some patient care areas. Water penetration resulted in mold, mildew, and musty odors in two patient rooms. As a result, patients were removed and the rooms were taken out of service. In addition, an adjacent stairwell used by patients and visitors showed signs of water penetration and plaster decay.

The facility's recent JCAHO review identified decaying plaster as an infection control issue. The Under Secretary for Health's Information Letter, Control of Moisture and Mold in VHA Facilities, dated May 4, 2005, identified the consequences of excess moisture and faulty building systems that may promote mold growth in medical center facilities. The AWE originally cited this issue in 1999. The medical center attempted to address and correct this issue with the submission of a Non-Recurring Maintenance (NRM) Project dated July 30, 1996. Project support documentation contained the following statements: "…interior leaks in several areas. Needs waterproofing. Resolve leaks and eliminate mold."

This project has not yet been funded as it remains below the VISN 6 funding threshold for NRM projects for FY 2006. Water penetration continues to damage walls and ceilings and poses an environmental concern for patients, visitors, and staff.

Recommended Improvement Action(s) 4. The VISN Director should ensure that the Medical Center Director requires that (a) Unit 2C fire safety doors function properly, (b) access to emergency medical gas shut off valves on the PACU is unobstructed, (c) patient room number signage is accurate, and (d) waste receptacles in patient care areas receive routine cleaning.

The VISN Director and the Medical Center Director agreed with the findings and recommendations and provided acceptable improvement plans. The Medical Center Director reported that bids for replacement of door closure were due on October 7, 2005; signage was posted prohibiting IV pump storage near the emergency gas shut off valves in the PACU and a new storage area designated; the medical center contracted with a vendor for signage correction project; and that waste receptacles were placed on a monthly cleaning schedule or replaced with new receptacles. We will follow up on the planned actions until they are completed.

Recommended Improvement Action 5. The VISN Director should reevaluate the NRM project prioritization and ensure that the patient care environment is structurally sound and protected from the spread of mold and mildew.

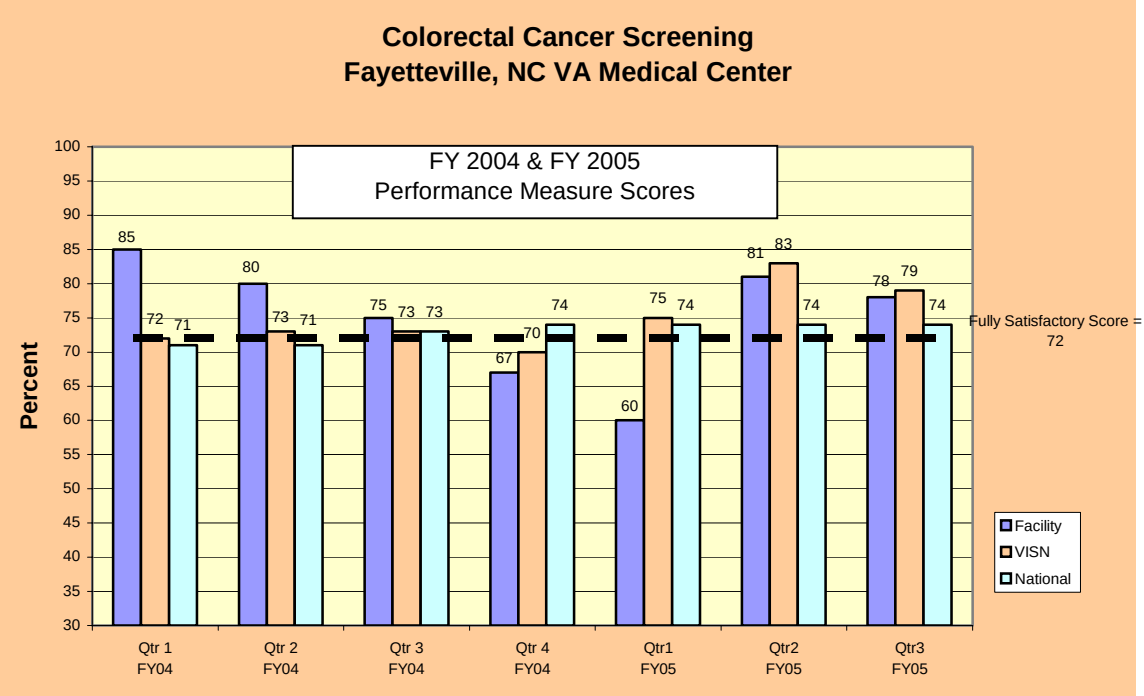
The VISN Director agreed with the findings and recommendations and provided acceptable improvement plans. The VISN Director anticipated that the VISN will receive additional supplemental Non-Recurring Maintenance funding in FY 2006 and requested that the medical center include this project for supplemental funding. We will follow up on the planned actions until they are completed.

Additional Area of Review

Colorectal Cancer Management – Colonoscopy Waiting Times Have Improved

Condition Needing Improvement. Clinicians did not provide timely consultation responses or diagnostic colonoscopies in FY 2004, but FY 2005 data showed significant improvement in timeliness. Timely diagnosis is essential to appropriate management of colorectal cancer (CRC) and optimal patient outcomes. The medical center provided appropriate CRC screening, and primary care providers (PCPs) promptly referred patients for further evaluation when indicated. We found that physicians informed patients of diagnoses and treatment options within reasonable timeframes and provided timely Surgery and Hematology/Oncology referrals. However, delays in response to initial consultation requests and scheduling difficulties caused significant delays in performing diagnostic colonoscopy procedures in FY 2004.

The following table illustrates the medical center's performance in FY 2004 and the first three quarters of FY 2005 for CRC screening:



We reviewed a random sample of 10 CRC cases diagnosed in FY 2004 and found that in 7 cases, significant delays occurred between presentation with symptoms and CRC diagnosis. Three cases were particularly problematic, with delays between 458 and 1,060 days. We found that PCPs were conscientious about follow-up to ensure procedures were completed.

The facility did not have gastroenterology (GI) staff, and general surgery staff physicians performed colonoscopy procedures in the operating room. We learned that one of the three general surgeons was on military leave for a year during this period. General Surgery clinic waiting times contributed to delays in scheduling and performing diagnostics. Patients were given a General Surgery Clinic appointment for a history and physical examination and a subsequent appointment for the colonoscopy procedure.

The medical center recognized these deficiencies and has since contracted with a local GI group to perform colonoscopy procedures at the facility on a fee basis. The average turnaround time for patients referred for colonoscopy in FY 2005 was 31 days.

As managers have addressed these issues and the medical center is meeting VHA Performance Measures for CRC screening and GI waiting times for FY 2005 to date, we made no recommendations.

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 7, 2005

From: Director, Mid-Atlantic Health Care Network (10N6)

Subject: **Combined Assessment Program Review of the VA Medical Center Fayetteville, North Carolina, Project Number 2005-02813-HI-0261**

To: John D. Daigh, Jr., MD, Assistant Inspector General for Healthcare Inspections

Thru: Director, Management Review Service (10B5)

1. I have reviewed and support the facility's responses to the CAP recommendations, which have been individually addressed and included in the attached MS Word document.

2. If you have any questions or require further clarification, please contact Janet S. Stout, Director, VAMC Fayetteville, via MS Exchange or at (910) 822-7059.

(original signed by:)

Daniel F. Hoffmann, FACHE

Attachment

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 7, 2005

From: Medical Center Director (565/00)

Subject: **Combined Assessment Program Review of the VA Medical Center Fayetteville, North Carolina, Project Number 2005-02813-HI-0261**

To: Network Director, VA Mid-Atlantic Health Care Network, VISN 6

Attached is Fayetteville's response to the Office of Inspection General (OIG) Combined Assessment Program Review recommendations from August 15-19, 2005 visit.

A response indicating concurrence is due via electronic submission to the Director, Management Review Service (10B5) by October 12, 2005 as prescribed by VA Policy MP-1, Part II, Chapter 23. A hard copy of supporting documents will be sent Federal Express to the VISN 6 office which also should be forwarded to the Director, Management Review Service (10B5).

(original signed by:)

JANET S. STOUT

Attachment

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

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

OIG Recommendation(s)

Recommended Improvement Action(s) 1. The VISN Director should ensure that the Medical Center Director requires that:

a. All areas containing controlled substances be inspected.

Concur **Target Completion Date:** 8/30/05

ACTION INITIATED: The Controlled Substance Coordinator collaborated with the Supervisor and Chief, Pharmacy to change the station Controlled Substance policy MCM# 00-8, section 6c(1-2) to require the "Chief of Pharmacy or designee will notify the Controlled Substance Coordinator of any change (additions or deletions) in location of where controlled substances will be stocked. This area will then be added to or deleted from the monthly control substance inventory. Any changes in the control substance location will be noted in the monthly control substance inspection report that is submitted to the Director". In addition, a new section requiring inquiry concerning any additions/deletions of Controlled Substance areas was added to the monthly inspection form. This information was communicated to all inspectors and the vault pharmacist in August 2005. Fayetteville VAMC has advised Central Office of the breakdown between the VistA system and Barcode Medication Administration System as it relates to narcotic tracking. Due to the system failure to reconcile, a paper trailed process has been implemented. Central Office recognized that this paper trail is a set back, however it is the only reasonable process at this time to ensure narcotic accountability.

b. The CS Coordinator periodically observe the inspectors to ensure that proper procedures are followed.

Concur **Target Completion Date:** 9/1/05

ACTION INITIATED: The Controlled Substance Coordinator re-educated inspectors in September prior to monthly Controlled Substance inspections for 100% compliance. Controlled Substance Coordinator began process of periodically observing inspectors for compliance with inspection process and establishing records of observation. Controlled Substance inspectors found 0 expired narcotics out of 50 inspected in the pharmacy vault. Also, the Controlled Substance Coordinator, Pharmacy Supervisor and Nursing collaborated and have implemented the use of VA Form 10-1043 to verify shift counts on 9/12/05. During September, Fayetteville VA had 100% compliance with verification of shift counts by inspectors.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the Medical Center Director requires that:

a. GIP records contain accurate inventory balances.

Concur **Target Completion Date:** 10/31/05

ACTION INITIATED:

1) Wall-to-wall inventories are to be ongoing and held on a monthly basis to ensure records remain accurate.

2) Engineering and Environmental Service Inventory Control Points are being centrally located to the Warehouse area to allow the scan of any item being distributed for use. Environmental Management Service and Engineering Inventory Control Points are being dispersed to individual work areas as secondary distribution points in order to maintain accuracy levels.

3) Dental, Imaging and Laboratory Inventory Control Points will become secondary inventory points to Supply Processing and Distribution allowing dispersement to these areas as done with medical ward supply closets.

4) Balances for seven identified Inventory Control Points were adjusted on 8/17/05 to correct for over/under stated dollar amounts.

Responsibility: Chief, A&MM

b. ICP stock usage is entered into GIP timely.

Concur **Target Completion Date:** 10/31/05

ACTION INITIATED: ICP stock usage will be entered into GIP timely. To ensure Inventory Control Points accuracy, barcode scans will be accomplished in order to re-supply and show timely stock usage for Engineering, Dental, Environmental Management Services, Laboratory and Imaging. Daily scans will be performed in Engineering and Environmental Management Service Inventory Control Points when centrally located to the Warehouse. When implementation is complete the Inventory Control Points will only be Supply Processing and Distribution, Warehouse, Engineering and Environmental Management Service.

Responsibility: Chief, A&MM

c. Missing bar code labels are replaced.

Concur **Target Completion Date:** 8/19/05

ACTION INITIATED: New barcode labels replaced on 8/19/05 and will be reviewed at a minimum twice a week. New labels will be replaced anytime they are not readable or a new item is added to the Inventory Control Point.

d. GIP records contain accurate nomenclature and units of issue information.

Concur **Target Completion Date:** 12/15/05

ACTION INITIATED: Each Inventory Control Point has been reviewed and correct information has been entered for nomenclature and units of issue. New information entered will be verified as items are added to each inventory. Staff have also been asked to be mindful as they utilize supply to communicate with Acquisition & Material Management Staff if a barcode legibility has been compromised.

Recommended Improvement Action(s) 3. The VISN Director should ensure that the Medical Center Director requires that:

a. Unused accounts be terminated in both IFCAP and Citibank's proprietary system.

Concur **Target Completion Date:** 9/15/05

ACTION INITIATED: Seven out of ten accounts were cancelled on 8/16/05 in IFCAP and Citibank. Two (2) cards were closed in IFCAP and in Citibank on 9/8/05 and 9/15/05. The one remaining card was closed in Citibank on 7/25/05 prior to OIG review and in IFCAP on 9/8/05. Process is in place to ensure that all accounts are terminated as required.

b. Twenty-five percent of all cardholder accounts are reviewed quarterly.

Concur **Target Completion Date:** 10/7/05

ACTION INITIATED: The Medical Center and VISN interpreted the 25% quarterly review requirement to mean for individual cardholders and not cardholder accounts, resulting in a lower review rate than was required. Fayetteville VAMC has corrected the process. 100% of all cardholder accounts have been reviewed for FY05. A system is now in place that will ensure that 100% of all cardholder accounts will be reviewed each Fiscal Year. This will be accomplished by reviewing 25% of cardholder accounts quarterly.

Responsibility: Chief, Business Office

Recommended Improvement Action(s) 4. The VISN Director should ensure that the Medical Center Director requires that:

a. Unit 2C fire safety doors function properly.

Concur **Target Completion Date:** 10/31/05

ACTION INITIATED: Purchase order request entered on 9/22/05 for emergency replacement of door closure. Response from bids are due October 7, 2005. Completion for the installation of the door is projected for 10/31/05.

Responsibility: Chief, Facilities Management Service

b. Access to emergency medical gas shut off valves on the PACU is unobstructed.

Concur **Target Completion Date:** 9/26/05

ACTION INITIATED: Signage installed to designate area as a no storage area was completed on 8/30/05. On 9/19/05 the OR Nurse Manager completed education with surgical staff regarding the new location for storage of infusion pumps. All infusion pumps have been moved to the lower right corner of the Post Anesthesia Care Unit. A "No Storage" sign has been mounted on the wall at the entrance to the hallway. The statement, "No IV Pumps stored near gas shut off valve areas" has been added to the Post Anesthesia Care Unit Daily Checklist. Random rounds are conducted to ensure compliance.

Responsibility: Chief, Facilities Management Service

c. Patient room number signage is accurate.

Concur **Target Completion Date:** 12/15/05

ACTION INITIATED:

1) Purchase Order 565-C50237 was obligated on July 1, 2005 for $80,575 to correct interior signage in the medical center.

2) Vendor: Innerface Architectural Signage, Contract #V246P-01448.

3) Current status: Contracting Officer Technical Representative conducting final review to be completed by 10/14/05.

4) Estimated delivery of product 11/21/05.

5) Projected completion date is 12/15/05.

Responsibility: Chief, Facilities Management Service

d. Waste receptacles in patient care areas receive routine cleaning.

Concur **Target Completion Date:** 10/14/05

ACTION INITIATED: Waste receptacles in all patient care areas have been placed on a monthly cleaning schedule. Receptacles will be removed from patient care areas once per month or more often if necessary, and taken to the back dock area to receive a thorough cleaning. Nurse Managers will communicate the need for receptacle changes within their patient care units as needed. Examination of the condition of these receptacles will also be inspected during Environment of Care rounds. Receptacles that are damaged, rusted, or beyond cleaning will be replaced with new ones. New receptacles have been ordered to replace those that are currently beyond routine cleaning. Estimated delivery date of these receptacles is 10/14/05.

Responsibility: Chief, Environmental Management Service

Recommended Improvement Action 5. The VISN Director should reevaluate the NRM project prioritization and ensure that the patient care environment is structurally sound and protected from the spread of mold and mildew.

Concur **Target Completion Date:** 9/30/07

ACTION INITIATED: The system used to score and rank the proposed Non-Recurring Maintenance (NRM) projects in VISN 6 is very comprehensive and takes many factors into consideration. Medical Centers are encouraged to submit up to five Non-Recurring Maintenance Projects for funding consideration each fiscal year. This gives the VISN forty (40) projects to review, score and rank based on a defined system that includes points for Facility Condition Scores of "D" or "F", Citations, VISN priority and VAMC priority. VISN Priority is recommended by the VISN Engineers based on justification and perceived need of the project. Medical Center priority is determined by the Medical Center Director. At the conclusion of the process, the projects are sorted in priority order based on their cumulative scores. The list of proposed Non-Recurring Maintenance Projects are submitted to the VISN Capital Asset Board (CAB) with a membership of management, clinical, contracting and engineering staff from our eight medical centers. Once approved by the VISN Capital Asset Board, the Network Director gives final approval of the Non-Recurring Maintenance Projects based on our funding levels of that year's Fiscal Year budget.

Unfortunately, not all projects submitted are funded as they are competing with projects submitted from eight medical centers. The proposed Exterior Maintenance project submitted by Fayetteville, NC has not yet been funded. However, we did fund new roofs for Fayetteville which is the first step in addressing the spread of mold and mildew in the buildings. It is anticipated that the VISN will receive additional supplemental Non-Recurring Maintenance funding in FY06 and the VISN has requested that Fayetteville include this project for supplemental funding.

OIG Contact and Staff Acknowledgments

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Appendix D

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