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OFFICE OF INSPECTOR GENERAL

Office of Audits and Evaluations

VETERANS HEALTH ADMINISTRATION

Equipment and Supply Mismanagement at the Hampton VA Medical Center, Virginia

REVIEW | REPORT #19-00260-215 | SEPTEMBER 26, 2019

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Executive Summary

The VA Office of Inspector General (OIG) conducted this review in response to an August 2018 confidential hotline complaint that alleged mismanagement of both nonexpendable equipment and expendable medical supplies resulted in wasted funds and canceled medical procedures at the Hampton, Virginia, VA Medical Center (the facility). Equipment classified as "nonexpendable" generally costs more than $300, has a life expectancy of two years or more, and is of a sensitive nature which requires accountability or control.[1] Examples of nonexpendable equipment include refrigerators, stretchers, and anesthesia carts. "Expendable" supplies are disposable items typically for single use such as gloves, syringes, and bolts.[2] The Generic Inventory Package (GIP) provides a method for improving inventory control and accountability for expendable supplies.[3]

The review focused on these six allegations:

1. Equipment valued at approximately $563,400 was left unused in an unmarked operating room storage area for several years.
2. Equipment was stored in the supply chain warehouse for several years.
3. There was no inventory system to track or order operating room supplies for at least two years.
4. Staff ordered too many supplies that then expired or became overstocked, which the complainant referred to as "excessed."
5. Additional costs were incurred to order supplies overnight, and operating room cases were canceled in some instances because the supplies were unavailable.
6. The facility chief logistics officer (CLO) conducted the fiscal year (FY) 2017 and 2018 quality control reviews, and the identified deficiencies had not been addressed.

What the Review Found

The OIG grouped the allegations into three areas to address the distinct issues associated with nonexpendable equipment management, expendable supply ordering, and quality control reviews. The OIG review also examined the causes for any identified deficiencies.

[1] VA Handbook 7002/1, *Logistics Management Procedures*, April 14, 2011.

[2] GIP User Training Guide, December 2015.

[3] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018; and *GIP User Training Guide*, December 2015.

An Unmarked Storage Room and Warehouse Accumulated Equipment for an Undetermined Time

The OIG substantiated the allegations related to amassing nonexpendable inventory management. Specifically, the OIG team found that equipment valued at approximately $1.8 million in an unmarked second-floor storage room and a warehouse basement had been held for an undetermined amount of time. The OIG team identified 139 nonexpendable items in the storage room that had inaccurate information in the Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS), which explains why facility staff were unable to locate some of the items the OIG team found. Further, the team identified 189 nonexpendable items in the warehouse basement that were later removed without a clear documentation trail. Even though the items were scheduled for removal from the area before the OIG team's site visit, these control weaknesses put assets at risk of loss or theft.

Lack of Inventory System Usage Led to Improper Expendable Supply Ordering

The OIG partially substantiated the allegation that the facility did not have an effective inventory system in place to track or order operating room supplies for two years. Although the facility had GIP in place, Logistics Service staff were not fully using GIP to manage or order expendable supplies for the operating room. Therefore, the information in the system was unreliable. Logistics management did not monitor staff use of GIP to accurately maintain on-hand levels or manage supply item receipt and distribution. The underutilization of GIP resulted in inaccurate and missing inventory information that directly affected staff's ability to correctly order supplies for the operating room.

The OIG substantiated the allegation that facility staff ordered too many expendable supplies, leading to overstocked and expired supplies with physical evidence of wasted stock with a total value of about $8,100 for the expired supplies. An expendable inventory management specialist provided spreadsheets listing 85 different types of supplies with 322 total individual supplies that expired between September 2016 and January 2019. This included a disposable polymer handpiece that expired in September 2016, 24 sutures that expired in January 2018, and 11 surgical staplers that expired in June 2018.

This overstock occurred because facility staff did not fully use the auto-generate function in GIP to order quantities of supplies based on usage and need. Logistics staff failed to use GIP, resulting in inaccurate and unreliable information such as the physical quantities on hand that were higher than the normal stock levels. As a further complication, the OIG team found expired supplies intermingled with unexpired supplies, making it difficult to identify and prevent wasted stock.

The OIG did not substantiate the allegation that operating room procedures were canceled due to the lack of required supplies nor that thousands of dollars were spent weekly to have supplies sent overnight for the operating room to ensure availability. Although the OIG team did not identify specific cancellations, the identified inventory management issues were found to increase the risk of necessary supplies being unavailable when needed to provide care for veterans.

Quality Control Review Deficiencies Were Not Effectively Addressed

The OIG did not substantiate the allegation that the facility's CLO conducted the FY 2017 and FY 2018 quality control reviews. The OIG team found the Veterans Integrated Service Network (VISN) 6 CLO performed the required task, and this was consistent with Veterans Health Administration (VHA) guidance.[4] The VISN 6 CLO, together with the VISN 6 equipment manager and the Salisbury, North Carolina, VA Medical Center supply system analyst conducted the quality control reviews.

The OIG substantiated that deficiencies identified in the May 2017 and May 2018 quality control reviews had not been effectively addressed. The quality control reviews identified deficiencies such as a cluttered and overstocked operating room storage area and inventory points missing GIP barcode labels. The FY 2018 quality control review noted that all deficiencies should be corrected within 60 days from the date of review, with an August 2018 deadline for the corrective actions. The former facility director signed this document certifying the quality control review was conducted, and that action may be required within a certain time frame. However, inventory management issues identified in the reviews persisted at the facility as of the OIG team's site visits in October and December 2018, at least two months after the corrective actions should have been completed.

Understaffing and Inadequate Oversight Led to a Breakdown in Inventory Management Practices

In determining how the deficiencies described above occurred, the OIG team found that the facility experienced both nonexpendable and expendable inventory management issues because of insufficient Logistics Service staffing and inadequate oversight to ensure staff complied with logistics management requirements. The Logistics Service had vacancies in key positions that support adequate inventory management. The former facility director, via the interim facility director, attributed this to system-wide budget constraints, senior management hiring priorities for the health care system, and inefficient human resources hiring processes. After the OIG team

[4] Assistant Deputy Under Secretary for Health for Administrative Operations, *FY17 Quality Control Review Requirements*, April 14, 2017.

initiated the review, the Human Resources Management Service requested and received approval to recruit for the positions in October 2018. The facility CLO position experienced high turnover and had four chiefs within two years, subjecting the Logistics Service to a lack of continuity in leadership. Moreover, the Logistics Service did not adequately manage equipment and supplies using the appropriate systems as required. Those failures were evident in the lack of inventory management for the second-floor storage area, an underutilized inventory management system that was not kept updated, noncompliance with disposal procedures for items no longer needed, and the failure to follow proper ordering procedures.[5]

Inventory Management Concerns Potentially Systemic Across Multiple VA Facilities

The OIG team identified deficiencies similar to previously reported inventory management issues occurring in other VA facilities, such as a lack of an accurate inventory and no reliable method for locating equipment and supplies.[6] The OIG reported issues with expendable inventory management at facilities affected by a migration of the system. In the *Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package*, the OIG identified that the facilities did not properly manage expendable supply inventory to ensure proper accountability.[7] This further demonstrates the issues were not isolated to the Hampton, VA Medical Center since the OIG identified similar problems in other facilities. VA facilities worldwide should consider implementing the recommendations contained within this report.

What the OIG Recommended

The OIG recommended that the facility director designate a custodial officer responsible for managing the inventory in the second-floor storage room; ensure Logistics Service management complies with requirements for lost or stolen equipment; and develop a process to make certain Logistics Service staff follow requirements for proper disposal of equipment that is no longer needed. The facility director should also verify and update AEMS/MERS information to ensure all equipment in the second-floor storage area is entered with accurate item status and location. The facility director should also ensure that all storage locations have barcodes to facilitate item tracking. The OIG also recommended the Logistics Service staff should use the auto-generate function within GIP, verify GIP reports monthly to ensure use of the system, and monitor

[5] VA Handbook 7002, *Logistics Management Procedures*, July 10, 2009.

[6] VA Office of Inspector General, *Critical Deficiencies at the Washington DC VA Medical Center*, 17-02644-130, March 7, 2018; VA Office of Inspector General, *Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package*, 17-05246-98, May 1, 2019.

[7] VA Office of Inspector General, *Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package*, 17-05246-98, May 1, 2019.

expired inventory weekly. The facility director should ensure a staffing plan is implemented to continue filling vacancies based on clinical and administrative workload to account for high turnover and ensure national requirements for ordering procedures are strictly followed to ensure the requestor, approving authority, and receiver are not the same individual. Finally, the facility director should implement a process to sufficiently address and correct deficiencies identified during quality control reviews in a timely manner.

Management Comments

The VA Mid-Atlantic Health Care Network (VISN 6) director concurred with the OIG's findings and recommendations. The Hampton VA Medical Center interim director concurred with Recommendations 1 through 12 and submitted acceptable corrective action plans for all recommendations. The OIG will monitor the facility's progress and follow up on implementation of the recommendations until all proposed actions are completed.

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Contents

Abbreviations

AEMS/MERS	Automated Engineering Management System/Medical Equipment Reporting System
CLO	chief logistics officer
FY	fiscal year
GIP	Generic Inventory Package
OIG	Office of Inspector General
U.S.C.	United States Code
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

In August 2018, the VA Office of Inspector General (OIG) received a confidential hotline complaint alleging deficiencies with the Hampton, Virginia, VA Medical Center (the facility) inventory management. The complaint alleged that there was overall mismanagement for both nonexpendable equipment and expendable medical supplies resulting in wasted funds and canceled medical procedures. Specifically, the complaint made the following allegations:

- Equipment valued at approximately $563,400 was left unused in an unmarked operating room storage area for several years.
- Equipment was stored in the supply chain warehouse for several years.
- There was no inventory system to track or order operating room supplies for at least two years.
- Staff ordered too many supplies that then expired or became overstocked, which the complainant referred to as "excessed."
- Additional costs were incurred to order supplies overnight, and operating room cases were canceled in some instances because the supplies were unavailable.
- The facility chief logistics officer (CLO) conducted the fiscal year (FY) 2017 and FY 2018 quality control reviews, and the identified deficiencies had not been addressed.

The OIG initiated a review of supply chain management in the specified storage areas at the facility. The OIG grouped the allegations into three areas to address the distinct issues associated with (1) nonexpendable equipment management, (2) expendable supply ordering, and (3) quality control reviews. The OIG team also examined what the causes were for any identified weaknesses in supply chain management.

Facility Supply Chain Management

The Hampton VA Medical Center is part of the Veterans Integrated Service Network (VISN) 6 and consists of one main facility and three outpatient clinics.[8] The facility provides comprehensive primary and specialty care in medicine, surgery, and psychiatry and provides 36 services to more than 220,000 veterans with 1,872 staff.[9]

[8] A VISN is a regional system of care working together to better meet local health care needs and provide greater access to care.

[9] As of December 2018, the facility provided 36 services and had 1,872 staff. As of January 2019, the facility served a veteran population of more than 220,000.

Supply chain management is the integration and alignment of people, processes, and systems to manage product and service planning, sourcing, purchasing, delivering, receiving, and disposal activities. The Veterans Health Administration (VHA) has a directive mandating that facility management establishes, operates, and maintains a supply chain management program that is effective, cost efficient, transparent, and responsive to customer requirements. Facilities are required to implement and follow all policies and procedures in VHA Directive 1761 as well as continually identify ways to improve supply chain management performance in support of high-quality veteran care.[10]

Each facility CLO is responsible for establishing a local supply chain management program that meets policy and operational requirements. The CLO is also responsible for the following:

- Completing a review of logistics staffing levels as program responsibilities change
- Promoting efficient use of supplies by ensuring that inventory points have proper supplies and stock levels[11]
- Establishing a Total Supply Support program at the facility[12]
- Using a VHA-approved inventory management system to maintain automated inventories
- Ensuring that the Logistics Service completes a physical inventory once per fiscal year (wall-to-wall or cycle count) of all expendable supplies within primary inventories with distribution points[13]

Nonexpendable Inventory Management

According to VA Handbook 7002/1, nonexpendable equipment generally has the following features:

- Normally has, but is not limited to, an acquisition cost of $300 or more
- A life expectancy of two years or more

[10] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

[11] Inventory point locations are where supplies are stored.

[12] The facility Logistics Service should manage the Total Supply Support program that involves management methods, practices, and procedures employed in determining goods and services requirements, and their funding acquisition, receipt, storage, issuance, and final disposition.

[13] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

- "Is of a sensitive nature which requires accountability or control regardless of cost, life expectancy, or maintenance requirements"[14]

Examples of nonexpendable equipment that may be found in medical centers include refrigerators, stretchers, and anesthesia carts. The VA's official equipment inventory system of record is the Automated Engineering Management System/Medical Equipment Reporting System, or AEMS/MERS.

All nonexpendable equipment requires basic accountability in AEMS/MERS. To do this, the facility accountable officer establishes an equipment record and assigns an equipment entry number for all nonexpendable items in AEMS/MERS.[15] An equipment entry number is the key identifier for the item and is printed on the barcode label attached to the equipment. In addition, the equipment is assigned to an equipment inventory listing that identifies which facility department owns the equipment.[16] These listings are used for conducting physical inventories.[17] As of October 2018, there were 99 equipment inventory listings for the different departments within the facility. The facility CLO is responsible for overseeing the process. Additionally, a physical inventory of all nonexpendable accountable equipment must be conducted annually.[18]

Expendable Inventory Management

Expendable supplies are disposable items typically for single use.[19] Examples of expendable supplies include gloves, syringes, and bolts.[20] The Generic Inventory Package (GIP) is the current software facilities use for inventory management of stock, and facility staff are required to enter all expendable supplies into GIP.

GIP is part of a larger software system—Integrated Funds Distribution, Control Point Activity, Accounting and Procurement— that provides information on supplies, equipment, vendors, procurement history, and control point activity.[21] The GIP portion provides a method for improving inventory control and accountability by enabling users to manage the receipt, distribution, and maintenance of expendable supplies. In addition, GIP allows the facility to

[14] VA Handbook 7002/1, *Logistics Management Procedures*, April 14, 2011.

[15] VA Handbook 7002, *Logistics Management Procedures*, July 10, 2009.

[16] AEMS/MERS User Training Guide, December 2015.

[17] VA Handbook 7002, *Logistics Management Procedures*, July 10, 2009.

[18] VA Handbook 7002, *Logistics Management Procedures*, July 10, 2009.

[19] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

[20] GIP User Training Guide, December 2015.

[21] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

manage and track item usage and costs.[22] Using GIP ensures that the Logistics Service can keep the necessary amounts of supplies on-hand and avoid understocking or overstocking. Simply put, when this information is updated and accurate it can provide an overview of the supplies that are coming into the facility, and show which service is using them and how often.

According to VHA Directive 1761, inventory is replenished through auto-generation in GIP.[23] The auto-generate order function identifies all supplies in the inventory system that are at or below the standard reorder point.[24] Inventory managers must use this function in GIP to create orders to replenish inventory.[25]

The facility CLO establishes stock levels for expendable supplies to ensure these supplies are always available. For an inventory point with expendable supplies to be considered fully established, all recurring and repetitive expendable supplies must be entered in GIP using an item master file that includes information such as the description, manufacturer, vendor, and price. The primary inventory point contains all expendable supplies for an inventory account, which are replenished by determining what is used and then placing orders outside of the facility to replace the used supplies. A secondary inventory point is a point of distribution for services within the facility and is generally replenished from supplies stored in the primary inventory point.

Another type of inventory location is a stand-alone inventory point. This inventory storage location is also the point of consumption, does not have distribution points since it is the end user, and is used when specialty expendable supplies are purchased for one area[26] (see "Stand-alone inventory point" in Figure 1). According to the CLO, as of April 2019 the facility had two primary inventory points, five stand-alone inventory points, and 36 secondary inventory points. Figure 1 illustrates the movement of supplies from receipt to the stand-alone inventory point and through the primary to the secondary inventory points.[27]

[22] GIP User Training Guide, December 2015.

[23] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

[24] Integrated Funds Distribution, Control Point Activity, Accounting and Procurement Version 5.1, Generic Inventory User's Guide, October 2011.

[25] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

[26] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

[27] These inventory points can vary at each facility based on the size and services offered.

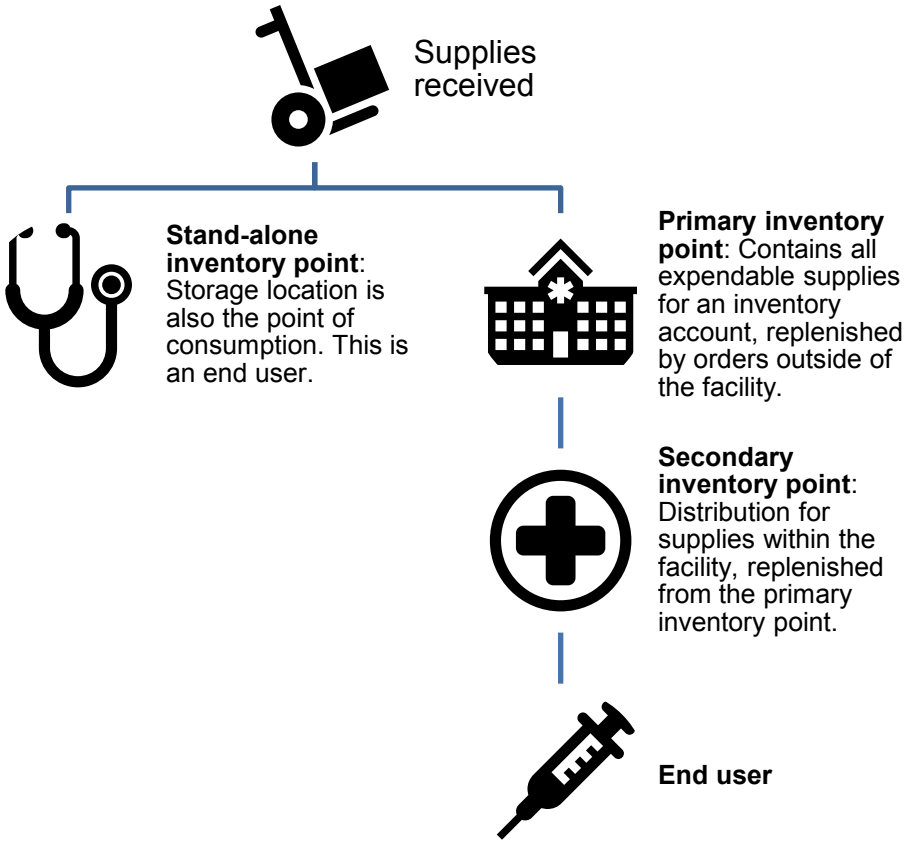

Figure 1. *Flow of supplies through inventory points*
Source: VA OIG analysis of VHA Directive 1761 and GIP User Training Guide

Results and Recommendations

Finding 1: An Unmarked Storage Room and Warehouse Accumulated Equipment for an Undetermined Time

The OIG substantiated the allegations related to amassing nonexpendable inventory management. The OIG found inappropriate inventory management practices for nonexpendable inventory management led to an unmarked storage room and warehouse basement having equipment valued at about $1.8 million for an undetermined time frame with incorrect information in AEMS/MERS. When nonexpendable inventory procedures are not followed, the physical location information for items in AEMS/MERS will be inaccurate, resulting in the inability to locate, track, and manage the equipment. Without being able to identify the date of initial storage, the facility lacked the means to prevent waste, damage, or obsolescence. Further, the control weaknesses for items stored in the warehouse basement put assets at risk of loss or theft.

What the OIG Did

This review included unannounced site visits to the facility in October and December 2018. The OIG team inspected the storage areas specifically related to the complaint for evidence that would point to whether the allegations related to nonexpendable inventory management were substantiated. The OIG team reviewed 486 items with a combined acquisition value of about $3 million.[28] The team reviewed AEMS/MERS information, purchase orders, equipment inventory listings, and relevant documentation required to assess the allegations. The OIG team interviewed managers and staff responsible for logistics and inventory management at the facility. Appendix A provides additional details on what the OIG did. Table 1 summarizes the team's review of nonexpendable inventory in storage locations identified in the complaint.

[28] The individual acquisition values listed in Table 1 were rounded to the nearest dollar. Due to rounding, the estimate for the total acquisition value is about $3 million. The OIG team primarily relied on the acquisition value provided in AEMS/MERS. In the absence of AEMS/MERS information, the team used items' purchase order acquisition values when possible. For 61 items, there was neither AEMS/MERS nor purchase order information available. For seven items, there was AEMS/MERS information, but no values populated in the records, so the total acquisition value listed in Table 1 for all items is understated.

Table 1. Nonexpendable Equipment Inventory

Storage location	Number of items inspected	Acquisition value
Operating room storage–second floor	139	$760,330
Warehouse–basement	189	$1,032,362
Warehouse–first floor	6	$83,486
Warehouse–third floor	152	$1,078,334
Total	**486**	**$2,954,512**

Source: VA OIG analysis of items inspected during site visit to Hampton VA Medical Center, October 15–19, 2018.

Mismanagement of Nonexpendable Equipment in Second-Floor Storage Room

The OIG team identified 139 nonexpendable items improperly located in the storage room, with a total acquisition value of about $760,000, and reviewed equipment entry screen shots from AEMS/MERS to determine each item's acquisition value, location, status, and disposition. However, the team could not verify the length of time the items had been stored in the location because this data was inaccurate in AEMS/MERS. Most items the team inspected appeared to have been used, however, some appeared to be new and were in boxes or plastic wrap as shown in Figure 2.

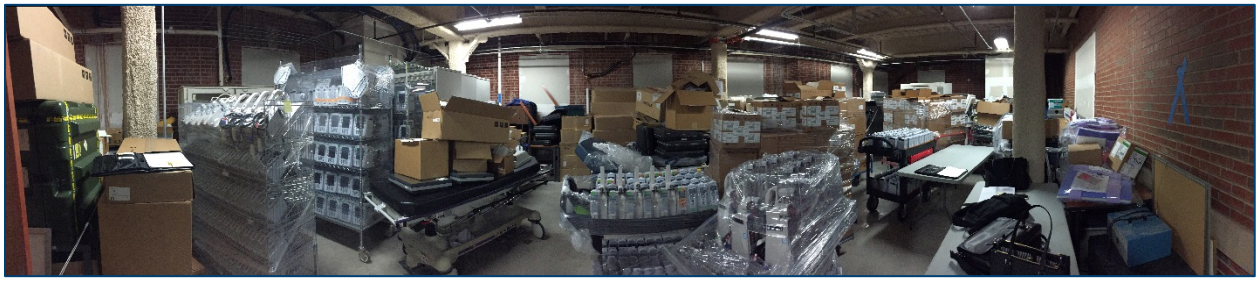

Figure 2. *Unmarked second-floor storage room*
Source: Picture taken on October 15, 2018, at 12:17 PM by a member of the VA OIG team.

Equipment Location Incorrect in Inventory System

All 139 pieces of equipment identified in the storage room had inaccurate AEMS/MERS location information, which explained why facility staff were unable to locate some of the items the OIG team found. The second-floor storage area did not have a room number, and facility staff did not adhere a barcode in or around the threshold that would allow the capability to scan nonexpendable items in and out of the room. In addition, VA Handbook 7002/1 requires that

inventories be conducted using barcode technology to the maximum extent possible.[29] However, the OIG team found 60 of the 139 items did not have barcode labels.

The AEMS/MERS User Training Guide explains that location barcode labels are printed and affixed to the physical location where items are stored, often put on the inside of the door frame. From that point, staff should scan the location label, then the equipment label. The data from the scanner is then uploaded to AEMS/MERS and the record is updated with both inventory date and location.[30] When this process is not followed, the physical location information for items in AEMS/MERS will be nonexistent or inaccurate, resulting in an inability to locate, track, and manage the equipment. Logistics Service staff may also not be able to perform an accurate verification of the equipment inventory listing for these items if the physical location in the system is incorrect.

Items Not in Inventory System

Forty-nine of 139 items were not listed in AEMS/MERS and, therefore, did not have a status or acquisition value. Some of these items included batteries, scales, and monitor arms. According to VA Handbook 7002/1, upon receipt of new equipment, Logistics Service staff should input the item in AEMS/MERS.[31] While some of the nonexpendable items had equipment entry numbers or serial numbers on the equipment, the facility Logistics Service staff were still unable to provide information out of AEMS/MERS. The facility CLO stated items that met the requirements to be categorized as equipment should have been added to AEMS/MERS. However, she also stated equipment had been procured and delivered to the facility without the Logistics Service staff's awareness. Since these items were not listed in AEMS/MERS, the OIG team concluded that facility staff were incapable of tracking or managing these 49 items.

The facility Logistics Service staff did not follow proper inventory management practices by failing to use AEMS/MERS to physically track and accurately manage nonexpendable inventory. As a result, facility management did not have an appropriate inventory of its equipment and could not account for everything for which it had responsibility.

Unused Printers

During the October 2018 site visit, the OIG team located nine unused printers in boxes on a pallet in the second-floor storage room. The complainant alleged that a pallet of equipment was received in October 2016 for about $347,000. The printers were part of the equipment order and purchased for a total cost of approximately $4,300.

[29] VA Handbook 7002/1, *Logistics Management Procedures*, April 14, 2011.

[30] AEMS/MERS User Training Guide, December 2015.

[31] VA Handbook 7002/1, *Logistics Management Procedures*, April 14, 2011.

The chief of pharmacy at the time of the OIG team's site visit stated the printers were part of a VISN initiative to improve pharmacy automation and told the OIG team he could not find the printers for some time. The chief stated that the printers should be in use, as opposed to being stored. When asked about why the installation was delayed after their receipt in October 2016, neither the chief of pharmacy nor the associate chief of pharmacy could recall what happened and indicated that biomedical engineering was responsible for installation. The chief of biomedical engineering told the OIG team that the installation was initially delayed because the printers were not approved for connection to the network. However, he further stated that the printers could not be found between October 2016 and October 2018.

In addition, although the printers had barcodes and were uploaded into AEMS/MERS, the location of the items was incorrect because they were stored in a room with no location label and could not be found for about two years.

Items Reported Lost or Stolen

The OIG team found five of 139 items located in the second-floor storage room that had previously been reported as missing and annotated in AEMS/MERS as lost or stolen. The five items included a mannequin, stretcher, and scales. The items were reported lost or stolen by the responsible service in October 2018. Logistics Service failed to complete the report of survey process within the required 60 days, in accordance with policy. The report of survey documents the findings, determines responsibility, records liability, if any, and is the official document used to adjust the record in the inventory system.

According to VA Handbook 7002, when an employee cannot find a piece of nonexpendable equipment, the employee will report the missing item to the supervisor or equipment inventory listing custodial officer, who is required to submit a report of survey. The custodial officer is usually a service chief at facilities and is responsible for equipment or items under his or her purview. The accountable officer assigns individuals to conduct a survey and submit a completed report of survey. The accountable officer has overall accountability for all equipment and is usually the CLO at facilities. The approving official, designated as the facility director or associate director, reviews the survey, and either approves the survey or can recommend additional action be taken. If the item cannot be located, it is designated as lost or stolen and removed from the equipment records. This process, from the employee notification through removal of the item from the system, should not exceed 60 days.[32]

The facility's Report of Survey Processing memorandum established procedures for the submission and timeliness of using the report of survey. It requires each instance of loss,

[32] VA Handbook 7002, *Logistics Management Procedures*, July 10, 2009.

damage, or destruction of government equipment to be formally investigated.[33] The Logistics Service provided the OIG team with two report of survey forms that were dated October 1, 2018, for the five items with a "lost or stolen" status that were found in the storage room by the OIG team. Each form had the same report of survey number and included the required signature blocks. However, the forms were incomplete because they lacked findings and recommendations of an investigation, approval or disapproval of action, and the CLO signature.

As of February 2019, the CLO stated that both report of survey forms were submitted in error and no investigation team was officially established. The Logistics Service provided a third report of survey form for one of the lost or stolen items. Although the report number of the report of survey was updated, it still did not include findings, an approval or disapproval, or the CLO signature. The form listed the facility associate director of operations as the approving authority and the CLO as the accountable officer. The OIG team could not determine whether a completed investigation was reviewed by the facility associate director of operations or the CLO. If the procedures in place are not completed, the Logistics Service cannot adequately justify adjusting the items' records in the inventory system.

Items Turned In and Improperly Disposed

Seven of 139 items the team identified had a status of "turned in" in AEMS/MERS, including two stretchers that were specifically listed in the complaint. Equipment that is no longer needed by a service should be returned to Logistics Service in accordance with local turn-in procedures.[34] Once an item is identified as no longer needed, the equipment inventory listing custodial officer submits an official form documenting the item's status. The warehouse staff should pick up the item and sign and return the documentation to the appropriate logistics official, who will then remove the item from the responsible service's equipment inventory listing and put it on a temporary listing until final disposition. Logistics staff are responsible for preparing the equipment for final disposition[35] and must advertise unrequired property.[36] Advertising allows unrequired property to be transferred to another VA facility or federal agency or disposed by other approved methods.[37]

The final disposition date represents the date the item was physically removed from the VA site.[38] All seven items showed a final disposition date in AEMS/MERS. However, the items were not removed from the facility. In addition, Logistics Service managers were not able to

[33] Hampton, Virginia, VA Medical Center Memorandum 590-90-16, *Report of Survey Processing*, December 19, 2014.

[34] VA Handbook 7002/1, *Logistics Management Procedures*, April 14, 2011.

[35] VA Handbook 7348, *Utilization and Disposal of Personal Property*, March 30, 2012.

[36] VA Handbook 7002/1, *Logistics Management Procedures*, April 14, 2011.

[37] VA Handbook 7348, *Utilization and Disposal of Personal Property,* March 30, 2012.

[38] AEMS/MERS User Training Guide, December 2015.

provide the official forms documenting the status for these items, and therefore, could not support proper turn-in of the items. The items had a higher risk of theft since they were not tracked and showed as disposed in the inventory system. An inventory management specialist stated he did not advertise for these seven items due to an understaffed Logistics Service.

The facility equipment inventory listing custodial officers should promptly make equipment that is no longer needed available for transfer to another service within their facility, other facilities, or other federal agencies. If equipment that is no longer needed cannot be used locally by other services within an officer's facility, it will be reported through the Agency Asset Management System, and screened for 10 days by VA. After this period, the items will shift automatically into GSAXcess, a system that allows other federal agencies to search for or obtain the items for another 21 days.[39] However, because the facility CLO did not ensure this process was followed as required and advertise the items, the Logistics Service missed an opportunity to recover costs and allow other facilities to utilize the equipment if possible.

Nonexpendable Equipment No Longer Needed Stored in Supply Warehouse for an Undetermined Time Frame

During the site visit in October 2018, the warehouse supervisor escorted the OIG team to all floors of the warehouse and the team inspected nonexpendable items. In total, the team inspected 347 nonexpendable items stored in the supply chain warehouse's basement, first floor, and third floor. The team photographed the items, barcodes, and serial numbers, as well as collected documents attached to the items where applicable. The team did not review items in the warehouse's second floor, which contained medical and surgical items considered expendable. On the third floor, the team inspected nonexpendable items such as medication carts, blood pressure monitors, patient scales, exam tables, a mannequin, and various other equipment. The team inspected five stretchers and one bed on the first floor of the warehouse that the warehouse supervisor stated were on hold pending project completion. The facility authorized the purchase of the stretchers and bed in June 2018, but there was no AEMS/MERS information for the equipment when the OIG team discovered the items in October 2018.

Equipment Missing After Disposal

The team found a large area in the warehouse basement that had 189 of 347 of the nonexpendable items, with a total acquisition value of about $1 million. These items included medical carts, patient lifts, monitors, vital sign monitors, defibrillators, refrigerators, a neuromuscular stimulator, and various other pieces of medical equipment. A warehouse material

[39] VA Handbook 7348, *Utilization and Disposal of Personal Property*, March 30, 2012.

handler stated he stored items in the basement to resell or send to UNICOR.[40] Figure 3 shows the volume of items stored in the warehouse basement that had been turned in and were awaiting disposition.

Figure 3. *Nonexpendable equipment in warehouse basement*
Source: Picture taken on October 15, 2018, at 3:14 PM by a member of the VA OIG team.

In December 2018, the team returned to the warehouse and found that most of the items previously inspected during the October 2018 site visit were no longer stored there. Instead, the team found items on pallets wrapped in plastic that were scheduled for removal from the area before the team's site visit in December. The warehouse supervisor explained the items were scheduled to be removed from the warehouse basement by UNICOR that week and provided a shipping authorization and manifest listing items scheduled for the pickup. However, 153 of the 189 items the OIG team previously identified in the basement during the October 2018 site visit were not listed on the UNICOR manifest. When questioned about the missing items on the list, the warehouse supervisor provided an updated UNICOR manifest that included 59 of the 153 missing items. To explain the difference, he stated there were two different shipments and said the manifest he initially provided was not complete. No one at the facility could provide a proper documentation trail to support the removal of the remaining 94 items missing from the manifest. The mismanagement of these items created a higher risk that the Logistics Service would lose these items and these control weaknesses put assets at risk of theft.

Failure to Follow Policy for Equipment No Longer Needed

The Logistics Service mismanaged nonexpendable items in the warehouse by not following the policy for disposing of items that were no longer needed. The OIG team found 146 items in the warehouse that showed a status of "Turned In" according to AEMS/MERS. An item with a turned-in status should be turned in to the Logistics Service for disposition or to be held in a state of temporary inactivity.[41] A facility *Equipment Turn-In* standard operating procedure stated the nonexpendable technician should receive electronic or paper turn-in forms from the user. A warehouse material handler confirmed that he signed the form when picking up items that were

[40] According to VA Handbook 7348, VA established a Memorandum of Understanding with UNICOR (Federal Prison Industries, Inc.) for the receipt of scrap or designated electronic equipment for reuse or recycling.
[41] AEMS/MERS User Training Guide, December 2015.

no longer needed from the services, made a copy of the document, and then provided it to the lead material handler to file. However, the Logistics Service could not adequately support the proper turn-in of items in accordance with policy. They could not provide turn-in documents showing when the material handler physically moved the equipment, and AEMS/MERS did not always capture the date an item's location was changed in the system. Therefore, the OIG team could not determine how long the items were stored in the basement.

Lack of Accountability for Equipment in the Second-floor Storage Room and Warehouse Basement

Logistics management failed to ensure staff listed all equipment in AEMS/MERS, or accurately updated the equipment status to indicate if the items were actively being used, turned in or disposed. All equipment in the second-floor operating room storage area that was listed in AEMS/MERS had inaccurate location information, which negatively affected staff's ability to properly track and manage the equipment. Additionally, the Logistics Service could not account for all equipment removed from the warehouse basement.

Logistics Service and other facility staff had varying knowledge of whether the second-floor operating room storage area contained equipment, and no one claimed responsibility for managing the storage room's equipment. The facility CLO stated that she was not aware of the second-floor storage room. However, the deputy CLO was not aware of any storage locations other than this room. An inventory management specialist stated the room became a "catch-all" used by Biomedical Engineering Service, Operating Room Service, and anyone else within the facility. An operating room nursing assistant who was detailed to the Logistics Service also stated the room was an inventory "catch-all" storage space.

Despite the room containing items that belonged to the Logistics Service, the deputy CLO stated the Logistics Service did not oversee this room and was not responsible for the equipment in the room. An inventory management specialist also stated the Logistics Service did not use or place items in this room. An operating room registered nurse stated he gave Logistics Service a listing of the items in the second-floor storage area but believed that logistics staff never addressed his listing or completed an inventory of the items. The OIG team could not determine whether other facility service staff who stored equipment in the area failed to notify logistics staff upon placing items there. The OIG team could not determine who placed the items in the room. The team could also not determine the length of time the items were stored in that location because the facility did not accurately use AEMS/MERS to track and manage the items.

Furthermore, there was confusion regarding who was responsible for updating the information in AEMS/MERS. The facility CLO stated it was the responsibility of the services to provide the location of the items on the equipment inventory listing, and that other facility services, outside of Logistics, had access to update the inventory system. The facility deputy CLO stated the logistics staff receive an email message regarding where equipment is located and will update the

record in AEMS/MERS. The chief of biomedical engineering stated he did not know who would be responsible for changing the status and stated they do not notify logistics staff to update the status. This outlines a clear disconnection within the Logistics Service regarding the procedures to follow when equipment is moved or needs to be updated in the system, which would also affect the process used by the other facility services.

In the OIG team's view, the failure by the facility management to manage equipment properly, as described in this report, constitutes a violation of Title 40 United States Code (U.S.C.) § 524(a)(1), (3), and (5). Those provisions require the VA to "(1) maintain adequate inventory controls and accountability systems for property under its control; … (3) promptly report excess property to the Administrator of General Services; … [and] (5) transfer or dispose of excess property as promptly as possible in accordance with authority delegated and regulations prescribed by the Administrator [of General Services]."[42]

Conclusion

The OIG determined the facility management and staff did not properly use AEMS/MERS to manage equipment. Items in an unmarked second-floor operating room storage area went unmanaged, and nonexpendable inventory could not be tracked or located because facility management did not ensure that all items were included in the system and that the system had accurate status and location information. The second-floor operating room storage area was not barcoded for proper inventory management, and facility management failed to ensure that logistics staff fully completed reports of survey for lost or stolen items. Additionally, equipment that was no longer needed sat in the warehouse basement because logistics staff failed to adhere to the proper turn-in and disposal processes.

Recommendations 1–5

The OIG made the following recommendations to the Hampton, Virginia, VA Medical Center director:

1. Assign a room number and designate a custodial officer to the second-floor operating room storage location and allocate responsibility to identify inventory and update the equipment inventory listing for the appropriate medical center services.
2. Ensure barcodes are affixed to all storage locations and items to properly track and identify nonexpendable equipment.
3. Verify and update the information in the Automated Engineering Management System/Medical Equipment Reporting System to ensure all equipment in the

[42] 40 U.S.C. § 524(a)(1), (3), and (5).

second-floor operating room storage location is entered into the system and has accurate item status and location.

4. Ensure Logistics Service management complies with requirements for completion of reports of survey for equipment identified as lost or stolen.
5. Develop and implement a process to ensure Logistics Service staff adhere to requirements for proper disposal of equipment that is no longer needed.

Management Comments

The VA Mid-Atlantic Health Care Network (VISN 6) director concurred with this finding and recommendations. The Hampton VA Medical Center interim director concurred with Recommendations 1 through 5. To address Recommendation 1, the second-floor operating storage space will be allocated to Engineering Service and assigned a room location number in the system for the printing of location barcodes. To address Recommendation 2, the Logistics and Engineering Services will review all equipment storage areas and ensure storage locations have been identified in the system. Missing barcode labels will be printed and affixed to the doors. To address Recommendation 3, the facility accountable officer and supervisory inventory management specialist will ensure the property management staff enters assets not currently in the system from the second-floor operating room into the Automated Engineering Management System/Medical Equipment Reporting System.

To address Recommendation 4, the accountable officer will revise the property management standard operating policies and procedures concerning the recording of inventory events. The accountable officer will ensure training is provided to the property management staff on the revised guidance. The accountable officer will track existing reports of survey through the national database and report of survey spreadsheet. To address Recommendation 5, the accountable officer will ensure training is provided to the Logistics Service staff on the proper disposal of equipment. The Logistics Service staff has been directed not to dispose of assets without proper documentation.

OIG Response

The Hampton VA Medical Center interim director's corrective action plans are responsive to the recommendations. The OIG will monitor the facility's progress and follow up on implementation of these recommendations until the proposed actions are completed.

Finding 2: Lack of Inventory System Usage Led to Improper Expendable Supply Ordering

The OIG partially substantiated that the facility did not have an inventory system in place to track or order operating room supplies for two years. Although the facility had a system in place, the OIG team determined the Logistics Service did not effectively use the system to manage supplies. The OIG substantiated the allegation that staff ordered too many expendable supplies at the facility, and this led to overstocked and expired supplies with physical evidence of wasted stock. Failure to use expendable inventory systems led to the inventory management issues with the expendable supply ordering. The OIG did not substantiate the allegation that operating room cases were canceled due to a lack of supplies available and that thousands of dollars were spent weekly to have supplies sent overnight for the operating room. Although the OIG did not substantiate the allegation that there were operating room case cancellations due to lack of supplies, continued inventory management issues and the unavailability of necessary supplies could affect the quality of care and increase risks to patients.

What the OIG Did

To evaluate the allegations related to expendable inventory management, the team judgmentally selected 78 unique expendable inventory supplies with a total acquisition value of approximately $538,800 found in seven different storage locations.[43] These locations were identified in the complaint or provided by facility staff during interviews. For these locations, the team physically counted the units for each of the 78 expendable supply types to determine the accurate quantity on-hand and compared those numbers to GIP on-hand inventory levels. The OIG team interviewed managers and staff responsible for logistics and inventory management at the facility. Appendix A provides additional details on what the OIG did. Table 2 summarizes the team's review of expendable inventory used for the operating room.

[43] The OIG team did not identify a population of expendable inventory for the facility because GIP data is not accurate and, instead, relied on the judgmental selection of supplies within the area stated in the complaint to physically count on-hand quantities. Nonstatistical sampling is used to show the existence of a problem and to formulate a conclusion about the reviewed items only.

Table 2. Expendable Supply Inventory for Operating Room

Storage location	Number of items	Acquisition value
Room D305	6	$122,592
Room C333	5	$123,040
Room C336	3	$84,285
Room C342	7	$13,806
Room C334	31	$104,941
Room D335X	2	$6,211
Room CG56	24	$83,963
Total	**78**	**$538,838**

Source: VA OIG analysis of supplies inspected during site visit to Hampton, Virginia, VA Medical Center, December 3–7, 2018
Note: Acquisition value was rounded to the nearest dollar. Detailed numbers within the above table did not sum exactly to the stated total because of rounding.

Logistics Staff Did Not Properly Use Inventory System to Order and Track Expendable Operating Room Supplies

Although the facility had an inventory system in place, staff were not fully using the system to manage or order expendable supplies for the operating room. In December 2018, the OIG team judgmentally selected 78 unique expendable supplies used for the operating room. The OIG team reviewed receiving information and usage history to determine the extent to which the facility managed and tracked these 78 operating room supplies in GIP. The team compared the physical quantities counted to on-hand inventory information in GIP and discussed the inaccurate GIP information with the expendable inventory management specialist.

Logistics management did not monitor staff use of GIP to accurately maintain on-hand levels or manage supply item receipt and distribution. The facility CLO is ultimately responsible for ensuring staff use the inventory system properly. The failure to sufficiently monitor system use resulted in inaccurate and incomplete GIP information as identified below. Although the team focused on the hotline allegations regarding the operating room, the OIG is concerned that these improper practices within Logistics Service are impacting supply management for other facility services.

Incorrect Supply Ordering Processes

The failure of Logistics Service staff to consistently use the GIP system resulted in the lack of, or inaccuracy of, necessary inventory information, which directly impacted the ability to correctly order supplies for the operating room. Logistics management did not ensure that staff followed the ordering procedures outlined in VHA Directive 1761, which requires the use of the

auto-generate function in GIP for creating orders to replenish inventory.[44] When staff do not use the auto-generate function, they risk stock levels becoming depleted or ordering excessive quantities of supplies.

Instead, a supply technician stated he would conduct a physical check of inventory quantities prior to ordering due to the unreliability of GIP information. He added that he believed they placed too many overnight orders, commonly for dialysis, and have had to request an overnight order to rectify a shortage of certain needles used for dialysis. He stated that he has had to work around supply shortages by driving about 170 miles round trip to and from the Richmond, Virginia, VA Medical Center to obtain supplies.

Further demonstrating the issue, a supervisory inventory management specialist stated staff are supposed to use the GIP auto-generate function to order supplies, but staff did not use the capability and would place phone orders to the vendors or manually manipulate the ordering information in GIP. A supply technician explained that when he purchased supplies for the operating room, the Logistics Service did not have a system for managing supplies other than recording supplies manually using pen and paper. Additionally, an expendable inventory management specialist stated the auto-generate function in GIP was set up but may have been inaccurate because item usage was not recorded. Further, she stated that stock levels may have been inaccurate since the Logistics Service was not using GIP prior to her being there. Without ensuring discipline in the inventory system, facility management and staff will rely on inaccurate GIP information, and in turn will negatively affect ordering processes leading to supply shortages or excess supplies.

Missing or Inaccurate GIP Information

Logistics staff did not use GIP to track and manage supplies as required.[45] The OIG found that 68 of the 78 unique expendable supplies used for the operating room did not have dates in GIP to indicate when the supplies were last issued or used. An expendable inventory management specialist explained that the Logistics Service began creating an operating room stand-alone inventory point in September 2018. Because the stand-alone inventory point was in progress, the supplies stored there did not have current usage information. Prior to the operating room stand-alone inventory point, 45 of the supplies were part of an operating room secondary inventory point, a point of distribution to the operating room. However, even when the supplies were stored in the operating room secondary inventory point, there was no information in GIP. Therefore, logistics staff were not properly scanning the supplies upon distribution.

[44] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

[45] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

Fifty-seven of the 78 supplies did not have a date in GIP identifying the last time the item was received. When a supply shipment arrives from the vendor, warehouse staff should process the receiving report for supply orders through the Integrated Funds Distribution, Control Point Activity, Accounting and Procurement system. Afterwards, the receiving report should be electronically accepted into the primary inventory point in GIP. According to the GIP User Training Guide, this action is a key step for stocking a primary inventory point and would adjust on-hand quantity levels in the system.[46] When these actions are not taking place, the supplies will not have receipt information in GIP.

Fifty-six of the 78 supplies had inaccurate on-hand inventory levels reported in GIP. The discrepancies for supplies that were either above or below the GIP on-hand inventory level ranged from one to 206 units of inventory. An expendable inventory management specialist attributed the discrepancies to miscounts, supplies being pulled since the last count, supplies being stored in a different place and then put back, and misplacement of supplies. She also stored supplies in her office, and one of the registered nurses added there was no supply technician to manage and distribute supplies.

Facility management relies on accurate on-hand inventory level information in GIP to determine availability and replenishment of supplies. When this information is incorrect, it negatively affects management's ability to correctly identify quantities of supplies needed to provide the delivery of healthcare services. Further, accurate receiving, usage, and on-hand level information in GIP ensures that crucial inventory levels are correct, such as normal stock level and reorder points. Compiled GIP usage data identifies the demand for supplies. Several inventory management reports rely on the information to provide facility management oversight for item ordering, distribution, and costs. Without accurate and complete receipt and usage information in GIP, facility management loses the ability to rely on the reports and cannot ensure staff are ordering the quantities needed based on demand and usage. This could result in inaccurate budget statements which negatively affect financial planning.

Supply Shelves and Bins Missing Required Barcode Labels

Logistics Service management also failed to ensure barcode labels were affixed to supply shelves and bins that held expendable supply inventory. For the seven locations reviewed, the OIG team found that two storage locations did not have barcode labels on all shelving and bins as required. VHA Directive 1761 requires the use of computerized barcode labels for all expendable supplies, and storeroom shelves must have barcode labels for all supplies to replenish and track

[46] GIP User Training Guide, December 2015.

inventory.[47] GIP uses barcodes to track every item of expendable inventory,[48] and the CLO is accountable for ensuring this requirement is met as part of the responsibility to establish a program that meets policy and operational requirements.[49]

During the site visit in October 2018, the OIG team inspected one storage location for operating room supplies that did not have barcode labels on shelving and racks where the supplies were stored. When the OIG team reviewed the storage location again during the December 2018 site visit, the team found that facility staff had affixed barcode labels to address the issue. However, during the same site visit, the team found another location that did not have barcode labels. When barcodes are not present in expendable supply locations, logistics staff lose the ability to efficiently and accurately identify supplies and use barcode scanners to update the inventory system when supplies are received or distributed.

Over Ordering Resulted in Excess and Expired Expendable Supplies

The OIG substantiated the allegation that facility staff ordered too many expendable supplies and maintained excess and expired supplies, and that there was physical evidence of wasted stock as the total value of the expired supplies was approximately $8,100. Facility staff did not fully utilize the auto-generate function in GIP to order quantities of supplies based on usage and need. This resulted in the facility maintaining excess supplies above normal stock levels. As a further complication, the OIG team found expired supplies intermingled with unexpired supplies, making it difficult to identify and prevent wasted stock.

Excess Supplies

During the review of the judgmentally selected expendable supplies, the OIG team found 51 percent of the 78 unique supplies had physical quantities on-hand higher than the normal stock levels, indicating staff ordered too many supplies. The range of the supplies' quantities over the normal stock levels was from one to 314 units of inventory, with an acquisition value of about $257,000. The normal stock level is based on the average daily usage of an item and number of days and should equal the maximum quantity the facility has on-hand. When a facility maintains inventory higher than the normal stock level, it is possible that facility staff will not be able to use all the supplies on-hand prior to the expiration date, which can lead to wasted stock.

Example 1 describes inventory with excess stock the OIG team inspected during its December 2018 site visit to the facility.

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[47] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

[48] GIP User Training Guide, December 2015.

[49] VHA Directive 1761(1), *Supply Chain Inventory Management,* October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

Example 1

The OIG team physically counted 320 microbore tubing sets, which are extension sets used to administer intravenous fluid and medications from a syringe to the patient. GIP inventory data showed 119 of these supplies on-hand with the normal stock level set at 50 microbore tubing sets. Not only was the on-hand inventory system information incorrect, the facility maintained an excess of 270 microbore tubing sets above the normal stock level valued at about $91,500. Compounding this issue, facility staff ordered a box of 100 additional microbore tubing sets in October 2018, despite already having an excess quantity on-hand. Although the excess supplies had not expired, because staff maintained quantities above the normal stock level and continued to order more, the supplies were at risk of expiration prior to use.

Expired Supplies

Seven of the 78 supplies had expired supplies intermingled with unexpired supplies in the storage bins, with expiration time ranging from 12 to 493 days. The total value of the expired supplies was approximately $8,100. Six out of the seven supplies had physical quantities on-hand that were more than the normal stock level, ranging from two to 85 units of inventory. Table 3 lists the details of the seven expired supplies that further exemplifies how the facility wasted government resources by overstocking.

Table 3. Items with Expired Supplies

Types of supplies	Quantities expired	Expiration dates	Number of days expired	Cost of expired supplies
Introducer, endotracheal tube (allows placement in difficult airway situations)	5	November 2018	12	$320
Angiography syringe	1	October 2018	67	$247
Fulgurating electrode (3FR) (delivers electrosurgical current to tissues during endoscopic surgery)	2	February 2018	309	$818
	6	November 2017	401	$2,455
Transmission gel/paste	7	August 2018	128	$525
	13	July 2018	159	$976
	2	August 2017	493	$150
Powerport clearvue (8FR) (implantable power injectable port)	2	October 2018	37	$1,256
	2	September 2018	68	$1,256
Fiberglass/resin tape	5	October 2018	67	$50
Murphy tube (9.0mm) (endotracheal tube)	3	October 2018	67	$5
	1	December 2017	371	$2

Source: VA OIG analysis of supplies inspected during site visit to Hampton VA Medical Center, December 3-7, 2018

Note: Number of days expired was calculated by using the last date of the site visit, December 7, 2018. Detailed numbers within the above table did not sum to the previously stated total of $8,100 because of rounding.

An expendable inventory management specialist provided spreadsheets listing expired supplies she found in the operating room between December 2018 and January 2019. The spreadsheets listed 85 types of supplies with 322 total individual supplies that expired between September 2016 and January 2019. This included a disposable polymer handpiece that expired in September 2016, 24 sutures that expired in January 2018, and 11 surgical staplers that expired in June 2018.

Two of the seven expired supplies were vascular supplies. A registered nurse stated the vascular program was not very big and stated that supplies frequently expired. She stated the ordering system became grossly mismanaged, and logistics staff would order more vascular supplies despite already having too much. In addition, an expendable inventory management specialist explained that expendable supplies frequently expired, especially the vascular supplies. She stated the facility did not have a vascular doctor at that time, so supplies were not being used as often, and that most supplies in excess were vascular supplies.

Logistics staff should have identified the expired supplies on-hand during required weekly checks for expiration and outdates as required in VHA Directive 1761.[50] The reviews help ensure expired supplies are not used in veteran care, and that the facility will have unexpired supplies available. The risk of using expired supplies could potentially impact veterans' quality of care because the safety or stability of the item cannot be guaranteed. Had the Logistics Service staff completed the verifications as required, they would have found the expired supplies in a timelier manner and removed them from the storage locations.[51] However, the expendable supplies expired because the staff failed to fully use the inventory system to manage and order expendable supplies. The inaccuracy within the system resulted in excess supplies.

Unavailability of Expendable Supplies Did Not Cause Case Cancellations or Excess Overnight Delivery Charges

The OIG team found no instances in which operating room cases were canceled due to lack of needed supplies or that thousands of dollars were spent weekly to have supplies sent overnight for the operating room to ensure availability. However, the facility remained vulnerable to the possibilities of delaying patient care or canceling cases due to the Logistics Service staff's failure to use GIP to track and manage supplies. To identify applicable incidents that resulted in operating room cases being canceled due to lack of supplies, the OIG team reviewed 1,832 patient event reports from October 2016 through November 2018 for the facility using key word searches. Although the OIG team did not identify any incidents that resulted in operating room case cancellations, the team identified the following example that described two incidents that resulted from a breakdown in communication about surgical supplies.

Example 2 explains two related incidents in July 2018 that involved missing supplies for two patients.

Example 2

On July 17, 2018, a patient safety manager reported two incidents in the Joint Patient Safety Reporting system for missing insufflation tubing (used to expand the stomach during laparoscopic procedures). The reports concerning both incidents stated the logistics supply technician listed the item as "Out" on the picking tickets when the case cart was prepared for surgery on July 13th. Both incident reports noted that to provide the patients necessary care, the operating room staff could have used an air seal instead of the tubing. However, the air seals were out of stock. Therefore, the operating room staff used the insufflation

[50] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

[51] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

> *tubing from the emergency stock to avoid canceling the procedures. Logistics staff placed an emergency overnight order on July 16th for the air seals that could be used in place of the tubing. The items were received on July 17th. When Logistics Service staff researched the issue on July 16th, they located tubing in stock. It was not clear why the logistics supply technician listed the item as "Out" when the case cart was prepared. To minimize the possibility of this situation occurring again, a logistics supervisor established procedures requiring a supervisor's signature when staff provided supplies. The reports stated the responsible staff's supervisor would retrain the individuals involved to check all areas for supply outages and notify a supervisor if they found any.*

Although the OIG did not identify specific case cancellations as alleged, the inventory management issues present the continued risk of inadvertent use of expired supplies or the unavailability of necessary supplies to care for veterans. Further, the team did not find egregious amounts spent to have items sent overnight to the operating room weekly.

Lack of Monitoring Exacerbated the Expendable Supply Management Issues

The Logistics Service management's lack of monitoring GIP usage and inventory management practices exacerbated the facility's issues with expendable supplies, particularly in the staff's use of GIP to order supplies and accurately maintain on-hand levels through managing supply item receipt and distribution. The facility CLO is ultimately responsible for ensuring staff use the inventory system properly. Logistics Service management could have prevented the issues by reviewing inventory reports on a recurring basis to ensure the accuracy of the system information and manage stock levels. The failure to sufficiently monitor system use resulted in the identified inaccurate and incomplete GIP information.

The Logistics Service management did not remain abreast of the expendable supply management practices taking place at the facility. For instance, the ability to monitor the tracking and replenishment of supplies is decreased when Logistics Service management does not ensure barcode labels are affixed to all supply storage shelves and bins. In addition, the OIG team found expired supplies dating back to August 2017, indicating Logistics Service management had not monitored and reviewed the weekly verifications of expired inventory through log sheets.

Conclusion

The OIG determined the facility management and staff did not properly use GIP to manage supplies. Supplies in operating room storage locations went unmanaged, and expendable inventory could not be tracked because facility management did not ensure information for the supplies was updated in the system. Some of the facility storage locations and supply shelves were not barcoded for proper inventory management. Additionally, the facility maintained

excess expendable supplies and logistics staff failed to adequately check for expired supplies. Because of the inappropriate supply management practices, facility management wasted funds and is at risk of not being able to provide veterans care when needed.

Recommendations 6–9

The OIG made the following recommendations to the Hampton, Virginia, VA Medical Center director:

6. Ensure Logistics Service staff use the auto-generate function within the Generic Inventory Package to identify the appropriate quantities for supply orders.
7. Require Logistics Service management to conduct monthly verifications of the Generic Inventory Package reports to ensure staff use of the system for the receipt and distribution of supplies.
8. Ensure barcodes are affixed to all storage locations, storage shelves, and bins to properly track and identify expendable supplies.
9. Ensure Logistics Service management monitors and reviews the weekly verification of expired inventory and ensures log sheets are properly annotated and maintained.

Management Comments

The VA Mid-Atlantic Health Care Network (VISN 6) director concurred with this finding and recommendations. The Hampton VA Medical Center interim director concurred with Recommendations 6 through 9. To address Recommendation 6, Logistics Service management will develop and implement a standard operating procedure to mandate and ensure the auto-generate function within the Generic Inventory Package is utilized daily. The supervisory inventory management specialist will ensure training is provided to the purchasing, inventory management, and medical supply distribution staff on the auto-generate function and produce a standard operating procedure. To address Recommendation 7, Logistics Service management will establish an internal control to ensure inventory management staff review the system reports. The supervisory inventory management specialist will provide refresher training to the purchasing, inventory management, and medical supply distribution staff on inventory package reports. A report review schedule is on file. To address Recommendation 8, Logistics Service management will conduct weekly reviews to ensure barcodes are affixed to all storages locations, storage shelves, and bins to properly track and identify the quantities for supply storage areas and to ensure full compliance with VA policy.

To address Recommendation 9, the following actions will be ongoing indefinitely to ensure weekly verification of expired inventory is properly annotated and maintained. Boxes for expired supplies have been put in every primary and secondary clean storage location. Logistics Service staff will capture the information on a log sheet for reporting purposes to include reports of

survey being initiated if the threshold is exceeded. Logistics Service management will conduct weekly reviews to visually inspect secondary inventory points and speak to customers about inventory support. Supply technicians will work with the inventory manager to eliminate expired inventory. The inventory manager will continue to monitor levels with clinical customers to ensure ongoing requirements are addressed.

OIG Response

The Hampton VA Medical Center interim director's corrective action plans are responsive to the recommendations. The OIG will monitor the facility's progress and follow up on implementation of these recommendations until the proposed actions are completed.

Finding 3: Quality Control Review Deficiencies Were Not Effectively Addressed

The OIG partially substantiated the ineffective changes made in response to deficiencies identified during quality control reviews. Although the OIG did not substantiate the allegation that the facility CLO conducted oversight (the FY 2017 and FY 2018 quality control reviews) for the Logistics Service under his or her authority, the OIG team determined that deficiencies revealed by the reviews were not effectively addressed. The Logistics Service had insufficient staffing levels and the former facility director and CLO had not taken effective corrective action to mitigate the inadequate oversight that led to the equipment and supply inventory management issues.

What the OIG Did

To evaluate the allegations related to the quality control reviews, the team reviewed signed memorandums and the corresponding checklists for the FY 2017 and FY 2018 quality control reviews. The OIG team analyzed the applicable areas within the checklists along with corrective actions and comments to determine if the facility improved between the fiscal years. The OIG team then compared the results of the latest quality control review with site visit observations and analysis. The OIG team interviewed managers and staff responsible for logistics and inventory management at the facility. Appendix A provides additional details on what the OIG did.

Quality Control Reviews Were Staffed According to Policy

VHA Directive 1761 outlines the VISN CLO responsibility for conducting an annual quality control review at their respective facility.[52] Moreover, the VISN CLO can appoint a designee to conduct the quality control review.[53] The facility CLO did not conduct the FY 2017 or FY 2018 quality control reviews. Instead, the VISN 6 CLO, VISN 6 equipment manager and the Salisbury, North Carolina, VA Medical Center supply system analyst conducted the quality control review inspections, which was in accordance with guidance.

Inventory Management Deficiencies Persisted from the Previous Fiscal Year

The OIG substantiated that deficiencies identified in the quality control reviews had not been effectively addressed. The OIG team analyzed both the FY 2017 and FY 2018 quality control

[52] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

[53] Assistant Deputy Under Secretary for Health for Administrative Operations Memorandum, *FY 17 Quality Control Review Requirements*, April 14, 2017.

reviews to determine if the checklist items indicated nonexpendable or operating room inventory management issues persisted from the previous fiscal year. Although the complainant did not explicitly allege issues with these quality control reviews relative to nonexpendable equipment, the OIG team reviewed responses to the checklist questions and identified discrepancies when compared to the site visit findings.

Equipment Lacked Accountability and Report of Surveys Not Completed Timely

For nonexpendable equipment, a checklist item for FY 2018 indicated the serial number, model number, and location were verified against equipment inventory listings when the inventory was conducted. All nonexpendable equipment requires basic accountability in AEMS/MERS.[54] Contrary to this, the same quality control review team indicated that not all equipment was accounted for within 13 months and further stated this included 12 medical equipment items. The corrective action plan was to conduct an inventory to locate the equipment and initiate a report of survey if the equipment couldn't be located.

The FY 2017 and 2018 quality control reviews indicated the facility completed the report of survey in accordance with current VA guidelines, and the process itself was completed within 60 days. However, as previously stated in this report, the OIG team found five items including a mannequin, stretcher, and scales located in the second-floor storage room that had previously been reported as missing in a report of survey and annotated in AEMS/MERS as lost or stolen. For these items, logistics staff failed to complete the report of survey process within the required 60 days. These items were last inventoried in May 2017, but there was no documented inventory of these items in 2018. The service did not report the equipment as lost until October 2018. In addition, the OIG team could not confirm that the appropriate officials completed an investigation of the loss. The FY 2018 quality control review indicated the facility was compliant with the report of survey timeliness requirement. However, the facility was not compliant in FY 2019.

Operating Room Inventory Not Managed Properly

The FY 2018 quality control review stated that the operating room storage areas were cluttered and overstocked. The corrective action plan was to reestablish operating room closets and affix labels. Another quality control review question addressed stock levels, including whether they were reviewed and adjusted appropriately. The reviewer provided a comment stating the operating room had several overstocked items. The survey response indicated facility management was not reviewing and adjusting stock levels appropriately to avoid overstocking and understocking. The corrective action plan was to reestablish stand-alone inventory points by

[54] VA Handbook 7002, *Logistics Management Procedures*, July 10, 2009.

August 2018. However, the Logistics Service did not begin to establish the operating room stand-alone inventory point until September 2018. In December 2018, the OIG team observed excess operating room supplies in an expendable inventory management specialist's office indicating persistent issues since the quality control review was conducted.

A question on the quality control review was whether computerized barcode labels identified each item within the inventory. The FY 2017 quality control review stated most areas had validated barcode labels that complied with GIP, however there were numerous supplies with labels for the Catamaran inventory system. The facility was no longer using this inventory system at the time of the quality control review in May 2017. The issues with the barcode labels persisted during the FY 2018 quality control review. In May 2018, the quality control review team indicated labels were missing from the operating room secondary inventory point. The corrective action plan stated that facility staff were reestablishing operating room closets and affixing labels. However, in October 2018, the OIG team inspected one operating room supply storage closet and found there were supplies with no barcode labels on the bins or shelving. In December 2018, the OIG team inspected a different operating room supply storage closet that had no barcode labels.

Another question in the FY 2017 and FY 2018 quality control reviews focused on whether the facility used GIP to manage all inventories. The FY 2017 quality control review included a comment that the facility moved from Catamaran to GIP in February 2017 and officially began using GIP in March 2017. Although the quality control reviews showed the facility was using the GIP system, the OIG team determined the facility did not fully rely on GIP to manage inventory and staff underutilized the system to order expendable supplies for the operating room.

Action Plan Not Completed by Due Date

The VISN CLO, or designee, had 10 business days to submit the findings and an action plan to the VHA Logistics SharePoint site to address the issues identified. The FY 2018 quality control review noted that all deficiencies for the findings should be corrected within 60 business days from the date of review. The corrective actions were due by August 2018. Any deficiencies requiring additional completion time must be approved by the VISN CLO and reported to the VHA Procurement and Logistics Office until complete.

The quality control review team provided the checklist with the noted deficiencies to the former facility director and deputy CLO. The former facility director signed this document certifying the quality control review was conducted, and that action may be required within a certain time frame. However, inventory management issues identified in the reviews persisted at the facility as of the OIG team's review, at least two months after the corrective actions should have been completed.

Understaffing and Inadequate Oversight Led to a Breakdown in Inventory Management Practices

The facility experienced both nonexpendable and expendable inventory management issues because of insufficient logistics staffing and inadequate oversight to ensure staff complied with logistics management requirements. The Logistics Service had vacancies in key positions that support adequate inventory management. The facility CLO position experienced high turnover and had four chiefs within two years, subjecting the Logistics Service to discontinuity in leadership. The Logistics Service did not adequately manage equipment and supplies using the appropriate systems as required.[55] Those failures were evident in the lack of inventory management for the second-floor operating room storage location, an underutilized inventory management system that was not kept updated, noncompliance with disposal procedures for items no longer needed, and the failure to follow proper ordering procedures.[56]

Understaffed Logistics Service

The facility Logistics Service had 42 authorized full-time equivalent positions. As of October 2018, 32 positions were filled while 10 were vacant. Out of the 10 vacant positions, one position directly reported to the facility CLO, three reported to the vacant nonexpendable supervisory inventory management specialist and the remaining five reported to the expendable supervisory inventory management specialist. These positions were crucial to inventory management, and their vacancies meant that several inventory management actions and proper ordering procedures did not occur as required by VA Handbook 7002.[57]

The four vacant nonexpendable inventory management positions included one supervisory inventory management specialist, two inventory management specialists, and one material handler. The deputy CLO acknowledged to the OIG team that they have not been able to work on turn-in procedures because they were understaffed. The deputy CLO stated she had been acting in the CLO position at one point while performing her deputy CLO duties, and performing the job functions of a vacant life cycle manager position. In addition, she was also performing duties for her former position as the material management supervisor, which had been vacant since 2015.

The Logistics Service was authorized three nonexpendable inventory management specialists, but only had one in the position to manage nonexpendable inventory. Due to understaffing, the deputy CLO stated the one individual in the nonexpendable inventory management specialist

[55] VA Handbook 7002, *Logistics Management Procedures*, July 10, 2009; VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

[56] VA Handbook 7002, *Logistics Management Procedures*, July 10, 2009.

[57] VA Handbook 7002, *Logistics Management Procedures*, July 10, 2009.

position was unable to accomplish tasks such as updating AEMS/MERS, uploading excess equipment to the General Services Administration website monthly, completing work on turn-in items, updating equipment meetings and minutes, and barcoding and processing new equipment weekly.

Logistics Service staff stated the warehouse also had staffing shortages, but they only had one vacant material handler position. According to the warehouse supervisor, equipment that was no longer needed remained in the warehouse basement because warehouse employees were unable to complete the disposal process due to being understaffed. However, the Logistics Service's inability to manage equipment within the warehouse was also due to their staff's failure to follow the national policies for disposing of the items no longer needed. As previously mentioned, the OIG team found 146 items in the warehouse that were turned in without adequate documents to support the action.

The five vacant expendable inventory management positions included two purchasing agents and three supply technicians. Facility staff noted that these vacancies caused a lack of segregation of duties for ordering, paying, and receiving expendable supplies. A supply technician stated he was responsible for ordering operating room supplies and received them as well. Another supply technician stated that Logistics Service vacancies had negatively impacted his ability to separate duties because he ordered and received supplies but should not be doing both functions. The supply technician stated he performed the job functions of a supply technician, purchasing agent, and inventory manager. Supply technicians should focus solely on their duties of managing expendable inventory and should not perform the functions of purchasing agents.

To further exacerbate this issue, the OIG team reviewed a purchase card order for four patient scales that were requested and approved by the same individual. VA Handbook 7002 mandates that purchases of nonexpendable equipment with the government purchase card be approved by the facility equipment committee and receipt coordinated through the facility accountable officer.[58] These key duties and responsibilities should be divided among different individuals to reduce the risk of error or fraud. When this does not happen, internal controls break down and the risk of error, fraud, waste, and abuse increases.

In August 2018, due to a potential trend in supply availability issues, the Hampton facility CLO and three nurses conducted a review of patient events from January 2018 through August 2018. The team was established to determine the root cause and contributing factors to the incidents and provide an analysis of the facility's system vulnerabilities, trends, or patterns not noticeable in individual case analysis. The review identified several reasons why the availability of supplies had been affected, including supplies being on back order, staff hoarding supplies, ineffective supply inventory management, questionable accuracy of normal stock levels, lack of communication, and lack of trust in logistics staff. The review also noted that the current

[58] VA Handbook 7002, *Logistics Management Procedures*, July 10, 2009.

inventory system was not fully automated and required some manual management, and the facility did not have an adequate number of inventory managers. Because of the lack of staffing, the logistics staff juggled multiple roles and responsibilities.

Due to the compounded role responsibility, the review identified an increased risk of neglecting inventory management, which could lead to decreased supply availability at the point of care. The action plan to address this issue at the facility included

- Shifting role responsibilities to match the national position description, decreasing workload, and clearly delineating roles as new staff are hired or transitioned into the Logistics Service;
- Developing a timeline for having roles and responsibilities shifted; and
- Including two additional inventory management specialists and two additional purchasing agents in the supply chain management FY 2019 Business Plan request.

At the time of the OIG team's site visit in December 2018, the facility had not completed these action items but had a plan to alleviate the understaffed Logistics Service. The Logistics Service management prepared the FY 2019 Business Plan and Budget Data briefing in October 2018 and addressed the aggregate review. The briefing indicated that the Logistics Service needed the two inventory management specialists as stated above, but only one purchasing agent to align with the national and VISN staffing methodology. Further, the briefing stated the facility faced challenges with staff burnout and people being resistant to change.

The former facility director had been in the position since June 2017, during the period mentioned in the complaint. According to VHA Directive 1761, the facility director is responsible for ensuring staff are allocated to the supply chain management program.[59] The former facility director, via the interim facility director, attributed the Logistics Service understaffing to system-wide budget constraints, senior management hiring priorities for the health care system, and inefficient human resources hiring processes. According to the chief of human resources management, the Human Resources Management Service did not receive approval to recruit for six of the 10 vacant Logistics Service positions until October 2018. Human Resources Management Service did not receive approval to recruit for the remaining four positions until December 2018. Two of the supply technician positions had been vacant since May and June 2017. The former facility director, via the interim facility director, stated 10 new positions were added to the Logistics Service during his tenure, but two of those positions were later disapproved for hire. Furthermore, he stated seven additional requests were disapproved and six of those requests were new and not on the authorized organization chart. He added that the

[59] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

facility management authorized and hired positions to meet the most immediate needs while meeting the overall budget.

Lack of Continuity in Leadership Resulted in Inadequate Management Oversight

The Logistics Service experienced instability in key leadership positions such as the CLO and deputy CLO, which contributed to the supply chain mismanagement. The facility experienced challenges staffing the CLO position during the two years mentioned in the complaint. Since 2015, four different individuals were either acting or permanently assigned as the facility CLO and the deputy CLO position was vacant until March 2018. Figure 4 displays the timeline for when the facility CLO position was occupied.

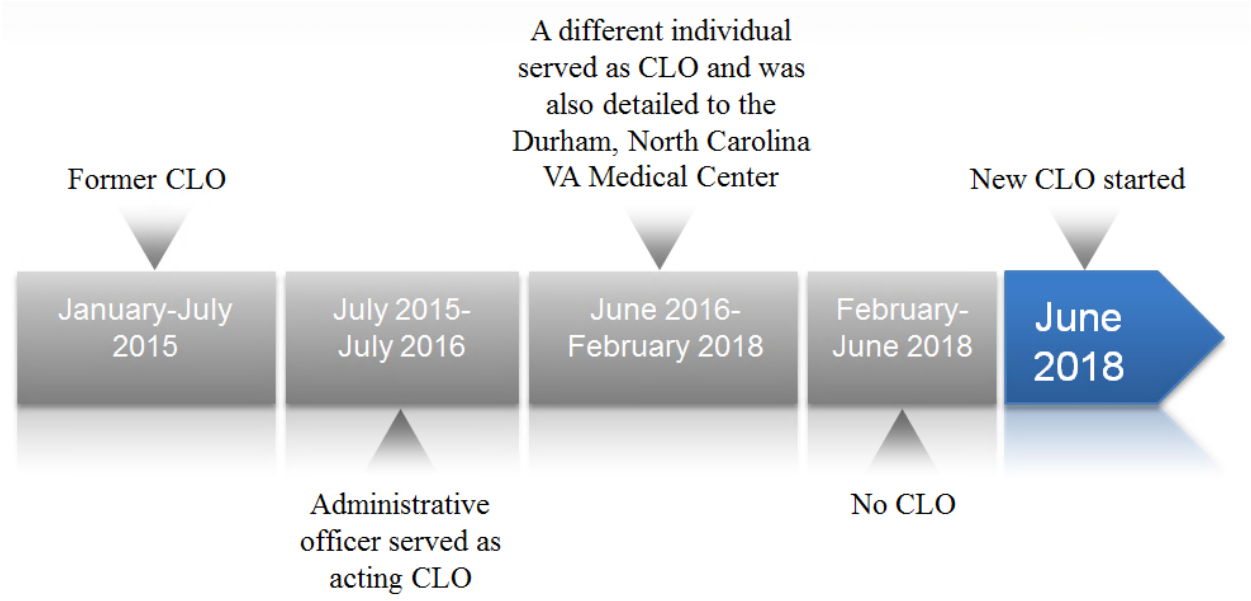

Figure 4. *Flowchart depicting the facility CLO turnover*
Source: VA OIG

A lack of continuity in leadership negatively affected the oversight of the facility's inventory management. The facility director and CLO are ultimately responsible for establishing the supply chain management program within a facility that meets policy.[60] As such, they are accountable for ensuring that staff are complying with requirements and ensuring the effective utilization of inventory systems to manage both nonexpendable and expendable supplies. For example, the CLO is responsible for ensuring all equipment assigned to the facility is accounted for and

[60] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

entered into the proper system.[61] Regarding expendable inventory oversight, inventory points are to be reviewed on a regular basis using inventory management system reports. For example, the Inactive Item Report in GIP should be reviewed no less than quarterly and can be used to identify supplies with no usage during a period of time and if staff are not using the system for distribution of supplies.[62] If reports were being reviewed as required, the CLO could have identified issues with inaccurate on-hand information and lack of receipt and usage information in GIP. Because there was inadequate oversight of the supply chain management functions, this left the facility susceptible to improper management of nonexpendable and expendable items.

In addition, the lack of oversight by the VISN led to the issues identified during the OIG team's review. The VISN CLO has a responsibility of conducting a review of operational practices to ensure compliance with regulatory and performance measure requirements.[63] Yet, the OIG team identified issues with improper storage due to the items' location being inaccurate and stored in an unlabeled room and disposal of equipment. If the VISN CLO had identified this unlabeled storage area during the quality control reviews, the issues could have been identified and addressed.

Inventory Management Concerns Potentially Systemic Across Multiple VA Facilities

The OIG team identified deficiencies similar to previously reported inventory management issues occurring in other VA facilities.[64] The OIG reported the following related deficiencies:

- Lacking an accurate inventory for equipment and supplies
- Finding equipment and supplies was difficult due to no reliable method for locating items in storage areas
- Not using the auto-generate function for placing supply orders due to lack of inventory system data
- Ordering the same items multiple times due to lack in confidence that supplies would be available when needed for patient procedures

[61] VA Handbook 7002, *Logistics Management Procedures*, July 10, 2009.

[62] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

[63] VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016; VHA Directive 1761(2), *Supply Chain Inventory Management*, October 26, 2018.

[64] VA Office of Inspector General, *Critical Deficiencies at the Washington DC VA Medical Center*, 17-02644-130, March 7, 2018; VA Office of Inspector General, *Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package*, 17-05246-98, May 1, 2019.

- Failing to account for excess items
- Using expired supplies
- Storing items in incorrect locations and with missing or incomplete barcode labels
- Not addressing understaffing and hiring problems
- Failing to segregate duties to prevent the same individual from purchasing and receiving or inventorying goods to ensure the integrity of procurement processes[65]

The Washington, D.C. VA Medical Center review prompted a deeper examination of the inventory management practices at other facilities. In May 2019, the OIG reported issues with expendable inventory management at facilities affected by a migration of the system. In the *Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package*, the OIG identified that the facilities did not properly manage expendable supply inventory to ensure proper accountability. During that audit, the OIG team identified the following related persistent expendable inventory management issues:

- Inaccurate inventory data led to supply understocking and overstocking.
- Discrepancies existed between the on-hand quantities listed in GIP and the physical counts.
- Storage shelves and containers did not have barcode labels at five of 11 facilities.
- Facilities maintained excess inventory for several medical supplies that expired or had the potential to expire prior to use.
- VISN quality control review process did not ensure facilities corrected the identified deficiencies.

This further demonstrates the issues were not isolated to the Hampton, Virginia, VA Medical Center since the OIG identified similar problems in other facilities.[66] VA facilities worldwide should consider implementing the recommendations contained within this report.

Conclusion

The OIG determined the facility's deficient inventory management practices identified in VISN quality control reviews were not fully corrected. These issues were caused by an understaffed Logistics Service, a lack of continuity in leadership, and inadequate oversight, and they ultimately resulted in the failure to properly manage nonexpendable and expendable inventory.

[65] VA Office of Inspector General, *Critical Deficiencies at the Washington DC VA Medical Center*, 17-02644-130, March 7, 2018.

[66] VA Office of Inspector General, *Expendable Inventory Management System: Oversight of Migration from Catamaran to the Generic Inventory Package*, 17-05246-98, May 1, 2019.

In addition, the facility failed to follow proper ordering procedures. Because of the inappropriate supply management practices, facility management wasted funds and is at risk of not being able to provide veterans care when needed.

Recommendations 10–12

The OIG made the following recommendations to the Hampton, Virginia, VA Medical Center director:

10. Ensure a staffing plan is implemented to continue filling vacancies based on clinical and administrative workload and includes contingencies for any positions with high turnover rates.
11. Ensure national requirements for ordering procedures are strictly followed to ensure requestor, approving authority, and receiver for all purchases are not the same individual.
12. Implement a process to sufficiently and timely address and correct deficiencies identified during the Veterans Integrated Service Network quality control reviews.

Management Comments

The VA Mid-Atlantic Health Care Network (VISN 6) director concurred with this finding and recommendations. The Hampton VA Medical Center interim director concurred with Recommendations 10 through 12. To address Recommendation 10, a staffing plan was developed after the new facility CLO conducted a workload analysis and presented the results to facility leadership in October 2018. Facility leaders will continue to utilize the data-based staffing plan that includes accurate numbers of authorized positions based on administrative workload and other appropriate measures to fill vacancies. Logistics Service management will conduct annual workload-based analysis to ensure the appropriate number of staff.

To address Recommendation 11, the Logistics Service has begun segregating duties. The supervisory inventory management specialist will ensure the national requirements for ordering procedures are strictly followed by auditing purchase cards on a quarterly basis. Existing staff will receive inclusive training regarding ordering procedures that outlines the roles of the requestor, approving authority, and the receiver. The Logistics Service has begun removing unnecessary access to system functions from current supply technicians who had approving authority and removed unnecessary purchase cards from staff. Training has been completed for 146 staff, including 110 cardholders and 36 administrative staff.

To address Recommendation 12, the facility CLO will continue to coordinate and communicate with the facility associate director and the VISN CLO to close pending action plans. The VISN CLO planned an on-site follow-up review in September 2019. The facility CLO will review the

open action items and provide status to the facility associate director towards closure in a weekly recurring meeting.

OIG Response

The Hampton VA Medical Center interim director's corrective action plans are responsive to the recommendations. The OIG will monitor the facility's progress and follow up on implementation of these recommendations until the proposed actions are completed.

Appendix A: Scope and Methodology

Scope and Methodology

The OIG initiated its review at the Hampton, Virginia, VA Medical Center from October 2018 to August 2019, and conducted unannounced site visits there on October 15 through 19 and December 3 through 7, 2018.

To conduct the review, the OIG team interviewed facility leadership and staff. The team also reviewed VHA and facility policies; inventory information from AEMS/MERS and GIP; budget information for FY 2018 equipment purchases and planned spending in FY 2019; purchase orders; patient event reports from the WebSPOT and Joint Patient Safety Reporting systems; FY 2017 and 2018 quality control reviews; and other relevant documents.

For nonexpendable equipment items reviewed, the OIG team requested equipment inventory screen print outs from AEMS/MERS to determine the usage status, location, acquisition value, responsible departments, turn-in and disposition dates, and disposition method. The team requested the equipment inventory listings for each applicable service responsible for the nonexpendable equipment to compare to the information in the inventory system, and requested local policies, budgetary data, purchase orders, and receiving documents related to the items reviewed.

For the expendable inventory supplies reviewed, the OIG team analyzed medical supply inventory information from GIP to determine the normal stock level, reorder point, on-hand quantity, total value, last date received, and last date used or issued.

During the unannounced site visits, the OIG inspected an unmarked storage room noted in the allegation that was located on the second floor of the main building; unmarked storage rooms on the ground and first floors of the main building; storage areas in the basement, first, second, and third floors of the warehouse; storage areas in the Mechanical, Biomedical Engineering, Prosthetics and Education Services in the main building; and adjoining buildings such as the education center, prosthetics wheelchair repair shop, electrical mechanical carpentry shop, VISN 6 Contracting office, electronics shop, interior design warehouse, and engineering staff buildings.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue or issues.

Fraud Assessment

The OIG team assessed the risk that fraud, violations of legal and regulatory requirements, and abuse could occur during this review. The team exercised due diligence in staying alert to any fraud indicators by taking actions such as:

- Developing lists of potential fraud risks and ratings;
- Asking the facility management what controls they have in place to prevent fraud, waste, and abuse;
- Analyzing equipment inventory system data and procurement documents for anything out of the ordinary or not satisfactorily explained;
- Analyzing judgmentally selected medical supply inventory system data for anything out of the ordinary or not satisfactorily explained;
- Reviewing for altered or missing inventory data and documentation; and
- Reviewing for appropriate quality control reviews.

The OIG did not identify any instances of fraud or potential fraud during this review.

Data Reliability

The OIG team used computer-processed data obtained from facility logistics staff through inventory system screenshots to determine the inventory information within AEMS/MERS. The OIG team observed the facility staff accessing and providing the screenshots to ensure it was not modified or altered. The team also determined the inventory information within AEMS/MERS was unreliable for addressing the allegation and instead relied on a physical inventory of 539 nonexpendable items. The team used both AEMS/MERS information and physical observations to develop findings, conclusions, and recommendations.

The OIG team determined the on-hand inventory information within GIP was unreliable and instead relied on a physical count of quantities on-hand for 78 judgmentally selected expendable supplies at the facility. A limitation of physically counting the inventory is the possibility of miscounting supplies. However, the team mitigated this by requiring two auditors to count all 78 expendable supplies and verifying the count. Therefore, the team used a combination of GIP information and physical counts to develop findings, conclusions, and recommendations.

In addition, the OIG team used computer-processed data from the VHA National Center for Patient Safety and facility quality management staff to determine how expendable inventory management can affect patient risk at the facility. VHA National Center for Patient Safety staff provided the patient event reports from two different systems: WebSPOT and Joint Patient Safety Reporting. The team could not determine the reliability of the information in each system.

The team used the patient event reports to identify potential examples that validated the findings and conclusions that were developed.

Government Standards

The OIG conducted this review in accordance with generally accepted government auditing standards. Those standards require that the OIG plan and perform the review to obtain sufficient, appropriate evidence to provide a reasonable basis for the findings and conclusions based on the review objectives. The OIG believes the evidence obtained provides a reasonable basis for the findings and conclusions based on the review objectives.

Appendix B: Management Comments – VA Mid-Atlantic Health Care Network, VISN 6 Director

Department of Veterans Affairs Memorandum

Date: September 05, 2019

From: Director, VA Mid-Atlantic Health Care Network, VISN 6 (10N6)

Subj: Review of Equipment and Supply Mismanagement at the Hampton, Virginia, VA Medical Center (#2019-00260-R3-0001) – Draft Report

To: Assistant Inspector General for Audits and Evaluations (52)

I concur with the findings and recommendations of the Hampton VA Medical Center regarding the Office of Inspector General Unpublished Report regarding Equipment and Supply Mismanagement at the Hampton, Virginia VA Medical Center

(Original signed by)

DEANNE M. SEEKINS, MBA, VHA-CM

VA Mid-Atlantic Health Care Network Director, VISN 6

Appendix C: Management Comments – Hampton VA Medical Center, Virginia, Interim Director

Department of Veterans Affairs Memorandum

Date: SEP - 4, 2019

From: Interim Director, Hampton VA Medical Center (00)

Subj: Office of Inspector General Unpublished Report regarding Equipment and Supply Mismanagement at the Hampton, Virginia VA Medical Center

To: Director, Veterans Intergrated Service Network 6 (VISN 6)

1. Attached please find the Hampton VA Medical Center facility response to the Office of Inspector General Unpublished Report regarding Equipment and Supply Mismanagement at the Hampton, Virginia VA Medical Center.
2. If you have any questions regarding the information provided, please contact Lessile Geiger, Chief, Supply Chain Officer Hampton VA Medical Center. Mrs. Geiger can be reached at (757) 722-9961, ext 4733.

(Original signed by)

TAQUISA K. SIMMONS, Ph.D., LCSW

Attachment: (Facility Response)

Equipment and Supply Mismanagement at the Hampton, Virginia VA Medical Center Draft Report, Issued August 22, 2019

Rec number	Recommendation
01	Assign a room number and designate a custodial officer to the second-floor Operating room storage location and allocate responsibility to identify inventory and update the Equipment Inventory Listing for the appropriate medical center services.

Corrective Action Plan

Concur

In collaboration with the Chief of Engineering, the second-floor operating storage space will be allocated to Engineering. The space will be assigned a room location and a room number that will be entered in VISTA for the printing of a location barcodes. When a room number is entered into VISTA AEMS/MERS, the data for that space (square footage, usage, owner, etc.) will be entered into the Capital Asset Inventory (CAI) data system for accountability. Currently, the space is being used to store construction material. Until the construction is completed and the space is considered habitable and turned over to the hospital for use, this area is deemed a construction area and is off limits to unauthorized personnel and storage of equipment.

Recommendation Status

In Progress

Recommendation Target Completion Date

9/30/2019

Revised Target Completion Date

Rec number	Recommendation
02	Ensure barcodes are affixed to all storage locations and items to properly track and identify nonexpendable equipment.

Corrective Action Plan

Concur

SCM and Engineering will review all equipment storage areas by conducting a walk through the medical center, ensuring storage locations have been identified with a location in the space file system in AEMS/MERS. Missing space barcode labels will be printed and affixed to the doors. Follow-up on the implementation of this recommendation will be checked on during EOC rounds.

Recommendation Status

In Progress

Recommendation Target Completion Date

10/31/2019

Revised Target Completion Date

Rec number	Recommendation
03	Verify and update the information in the Automated Engineering Management System/Medical Equipment Reporting System to ensure all equipment in the second-floor operating room storage location is entered into the system and has accurate item status and location**.**

Corrective Action Plan
Concur

Facility Accountable Officer and Non-expendable Supervisor will ensure the non-expendable staff enters assets currently not in the system from the second-floor operating room into AEMS/MERS. Assets will be aligned/reconciled with the EIL Custodial Official by the Purchase Order and/or transaction procurement request. The remainder of the assets will be reconciled with the EIL Custodial Official or by turn-in process. SCM will advertise/post required property in accordance with VA Directive and Handbook 7348 and 7002.

Recommendation Status
In Progress

Recommendation Target Completion Date
10/31/19

Revised Target Completion Date

Rec number	Recommendation
04	Ensure Logistics management complies with requirements for completion of Reports of Survey for equipment identified as lost or stolen.

Corrective Action Plan
Concur

Accountable Officer will revise the property management standard operating policies and/or procedure concerning the recording of inventory events. Specifically, Report of Survey from property management policy in VA Handbook 7002, Logistics Management Procedures specified required steps and time frames for recording of key inventory events, upon receipt of the VA Form 1217. Accountable Officer will ensure training is provided to the non-expendable staff on the revised property management standard operating policy and procedure (SOP). Accountable Officer will track existing ROS through the ROS National database and through internal control ROS spreadsheet.

Recommendation Status
In Progress

Recommendation Target Completion Date
10/31/2019

Revised Target Completion Date

Rec number	Recommendation
05	Develop and implement a process to ensure Logistics staff adhere to requirements for proper disposal of equipment that is no longer needed.

Corrective Action Plan
Concur

The Accountable Officer will ensure training is provided to the non-expendable staff on the proper disposal of equipment. Accountable Officer/Facility Chief Supply Chain Officer has directed SCM staff that no assets are to be disposed of without proper documentation. All documentation is to be retained according to RCS 10-1. SCM will advertise/post required property in accordance with VA Directive and Handbook 7348 and 7002. Coding for each item will be properly documented by non-expendable staff to indicate action for items. Facility Chief Supply Chain Management will be updating several documents to streamline the process for transparency (Turn-In Standard Operating Procedure and shipping manifest). Accountable Officer will do spot checks on documents/records periodically.

Recommendation Status
In Progress

Recommendation Target Completion Date
10/31/2019

Revised Target Completion Date

Rec number	Recommendation language
06	Ensure Logistics staff use the auto-generate function within the Generic Inventory Package to identify to the appropriate quantities for supply orders.

Corrective Action Plan
Concur

SCM leaders will develop and implement a procedure (SOP) to mandate and ensure the auto generate function is utilized on a daily recurring basis within the Generic Inventory Package to procure supplies stocked in the supply primary inventories. Expendable supervisors will ensure training is provided to the expendable staff on to auto-generate and produce an SOP. Facility Chief SCM and Deputy SCM will do random spot checks

Corrective Action Plan

Recommendation Status
In Progress

Recommendation Target Completion Date
09/30/2019

Revised Target Completion Date

Rec number	Recommendation
07	Require Logistics management to conduct monthly verifications of the Generic Inventory Package reports to ensure staff use of the system for the receipt and distribution of supplies**.**

Corrective Action Plan
Concur

The SCM leaders will establish an internal control to ensure inventory management staff reviews the Generic Inventory system reports. The Expendable supervisor will re-train expendable staff on Inventory Package Reports. A Report Review Schedule is on file. Staff is to keep one month of reports in their 6-part folder for review purposes and adjustments. Supply chain staff also utilizes SCCOP/SCDIO data site to monitor/manage inventory data. Expendable supervisor will either train or coordinate a SCCOP/SCDIO representative to conduct training online on the SCCOP/SCDIO site lunch and learn for the facility SCM expendable staff. VISN Supply Chain staff is conducting weekly meetings and training sessions with facility supply chain staff to improve proficiency and direct efforts.

GIP Reports and Frequency
Comprehensive Item Report - Semi-Annual
Quantity Distribution Report - Semi-Annual
Conversion Factor Report - Quarterly
Inactive Item Report - Quarterly
Usage Demand Item Report - Monthly
Availability Listing Report - Monthly
Days of Stock On Hand Report - Monthly
History of Distribution Report - Monthly
Stock Status Report - Twice-Monthly (every 2 weeks)
Due-In Report - Weekly
Emergency Stock Report - Weekly
Packaging Procurement Discrepancy Report - Weekly
List Distribution Orders To/From Inventory Point - Daily
Abbreviated Item Report - As Needed

Recommendation Status
In Progress

Recommendation Target Completion Date
10/31/2019

Revised Target Completion Date

Rec number	Recommendation language
08	Ensure barcodes are affixed to all storage locations, storage shelves, and bins to properly track and identify expendable supplies**.**

Corrective Action Plan
Concur

To ensure barcodes are affixed to all storages locations, storage shelves, and bins to properly track and identify the quantities for supply storage areas and to ensure full compliance with VA policy, the Deputy SCM and the expendable supervisor will conduct weekly rounding with Environment of Care (EOC) ensuring barcode labels are affixed to shelving and bins. The Facility Supply Chain Management Officer will conduct spot checks of clean supply storage areas and track/document findings. SCM has implemented and placed tracking sheets in all authorized clean supply storage rooms in addition to tracking barcode labels on a weekly basis to ensure compliance.

Recommendation Status
In Progress

Recommendation Target Completion Date
9/30/19

Revised Target Completion Date

Rec number	**Recommendation language**
09	Ensure Logistics management monitors and reviews the weekly verification of expired inventory and ensures log sheets are properly annotated and maintained**.**

Corrective Action Plan
Concur

The following actions will be ongoing indefinitely to ensure weekly verification of expired inventory is properly annotated and maintained. An amnesty box for expired supplies have been put in every primary and secondary clean storage location. An SCM technician will capture the information on a log sheet for reporting purposes to include Report of Survey being initiated if the threshold is exceeded. The Deputy SCM and Expendable Inventory Supervisors will conduct weekly rounds to visually inspect secondary inventory points and speak to customers about inventory support. Supply Technicians reviews Par Levels with the IM to eliminate expired inventory: Inventory Manager will continue to conduct regular reviews of PAR levels with clinical customers to ensure ongoing requirements are addressed. Review of par levels will be discussed with and agreed to by the supported clinical services.

Recommendation Status
In Progress

Recommendation Target Completion Date
On going

Revised Target Completion Date

Rec number	**Recommendation language**
10	Ensure a staffing plan is implemented to continue filling vacancies based on clinical and administrative workload and includes contingencies for any positions with high turnover rates**.**

10. Corrective Action Plan
Concur

A staffing plan was developed in August after the new SCM chief conducted a workload analysis to determine the time, effort and resources necessary to carry out the department's operations, using other 1C like medical centers as a guide. The outcome was presented to the Medical Center leadership during the Business Plan presentation in October 2018. To prevent future staffing deficiencies in SCM, facility leaders will continue to utilize the data-based staffing plan (LEAF) to fill vacancies that includes accurate numbers of authorized positions by SCM service, based on administrative workload and other appropriate measures that include contingencies for staffing areas. SCM Leadership will continue to conduct workload-based analysis to ensure appropriate number of staff are in Supply Chain Management annually.

SCM leaders will continue to utilize the Standardization database plan to fill vacancies that includes accurate numbers of authorized positions by service. VISN personnel have conducted site visits and tours to review workload tasks to better understand facility staffing needs. VISN HR have begun working on a comprehensive approach to ensure vacancies are filled.

SCM Leader will continue to meet monthly for review hiring with the Human Resource Specialist until staffing on board or sufficient to current FTE ceiling.

SCM Leader have updated their organizational chart to include all positions required to accomplish mission goals. SCM Leader will continue to request vacant position or over ceiling positions in LEAF and in other forum established to include all positions required to accomplish mission goals. The organizational chart is currently being reviewed by the Veterans Integrated Service Network (VISN/Facility) Human Resources Officer (HRO) and will be forwarded to the Fiscal Chief, Quad Leaders, and Acting Interim Director for review and concurrence.

Recommendation Status
In Progress

Recommendation Target Completion Date
9/30/2019

Revised Target Completion Date

Rec number	**Recommendation language**
11	Ensure national requirements for ordering procedures are strictly followed to ensure requestor, approving authority, and receiver for all purchases are not the same individual.

Corrective Action Plan
Concur

SCM has begun the segregation of duties by announcing purchasing agent, and inventory management specialist positions. Currently SCM has (5) Inventory Management Specialist position advertised and one (1) Purchasing Agent pending HR review. Hampton has hired 3 out of 4 Purchasing Agents. The current purchasing team has received basic purchase card training provided by TMS and VISN 6 NCO Purchase Card Coordinator from August 2018 to present.

SCM expendable supervisor will oversee the national requirements for ordering procedures are strictly followed by auditing purchase cards on a quarterly basis. Existing staff will receive inclusive training regarding ordering procedures that outlines the roles of the requestor, approving authority, and the receiver.

VAMC Hampton SCM has begun removing certain menus and keys from current Supply Technicians that hold Control Point Official keys with approving authority. SCM is transitioning purchasing duties in a way that clinical services are not disruptive to purchasing agents. Unnecessary purchase cards have been removed from staff. Training has been completed for 146 staff (110 cardholders and 36 administrative staff).

Recommendation Status
In Progress

Recommendation Target Completion Date
10/31/2019

Revised Target Completion Date

Rec number	**Recommendation language**
12	Implement a process to sufficiently and timely address and correct deficiencies identified during the Veterans Integrated Service Network quality control reviews**.**

Corrective Action Plan
Concur

The Facility Chief Supply Chain Officer is the point of contact for the action plan and responsible for following up on completion of the actions timely within 90 days or request an extension through the Director to the VISN SCM Officer for approval. Any open items for FY18 have been moved to the FY19 QCR action plans. Chief of SCM will continue to coordinate and communicate with facility Associate Director and the VISN Chief SCM Officer to close out FY19 Quality Control Review action plans and show them as completed. VISN CSCO will conduct an on-site follow-up review September 9-11, 2019 to review all findings from the May 2019 QCR to provide status update and to provide additional staff training. The facility SCM Officer will review the open action items and provide status to Associate Director towards closure in the weekly "one on one" recurring meeting.

Recommendation Status

In Progress

Recommendation Target Completion Date
10/31/2019

Revised Target Completion Date

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

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