Highlights of GAO-11-391, a report to congressional requesters

Why GAO Did This Study

Department of Veterans Affairs (VA) clinicians use expendable medical supplies—disposable items that are generally used one time-and reusable medical equipment (RME), which is designed to be reused for multiple patients. VA has policies that VA medical centers (VAMC) must follow when purchasing such supplies and equipment, tracking these items at VAMCs, and reprocessing—that is, cleaning, disinfecting, and sterilizing—RME. GAO was asked to evaluate (1) purchasing, tracking, and reprocessing requirements in VA policies and (2) VA's oversight of VAMCs' compliance with these requirements, GAO reviewed VA policies and selected two purchasing requirements, two tracking requirements, and two reprocessing requirements. At the six VAMCs GAO visited, GAO interviewed officials and reviewed documents to examine the adequacy of the selected requirements to help ensure veterans' safety. GAO also interviewed officials from VA headquarters and from six Veterans Integrated Service Networks (VISN), which oversee VAMCs, and obtained and reviewed documents regarding VA's oversight.

What GAO Recommends

GAO is making several recommendations for VA to address the inadequacies identified in selected tracking and reprocessing requirements and the weaknesses in its oversight over selected purchasing and reprocessing requirements. VA concurred with these recommendations.

View GAO-11-391 or key components. For more information, contact Randall B. Williamson at (202) 512-7114 or williamsonr@gao.gov.

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VA HEALTH CARE

Weaknesses in Policies and Oversight Governing Medical Supplies and Equipment Pose Risks to Veterans' Safety

What GAO Found

GAO found that the VA tracking and reprocessing requirements selected for review are inadequate to help ensure the safety of veterans who receive care at VAMCs. GAO did not identify inadequacies in selected VA purchasing requirements that may create potential risks to veterans' safety. GAO found the following:

- Tracking requirements. Because VA does not require VAMCs to enter information about certain expendable medical supplies and RME in their facilities into VA's inventory management systems, VAMCs may have incomplete inventories of these items. This, in turn, creates potential risks to veterans' safety. For example, in the event of a manufacturer recall involving these items, VAMCs may be unable to readily determine whether the items are in their facilities and should be removed and not used when providing care to veterans.
- Reprocessing requirements. Although VA requires VAMCs to develop device-specific training for staff on how to correctly reprocess RME, VA has not specified the types of RME for which this training is required. VA has also provided conflicting guidance to VAMCs on how to develop this training. This lack of clarity may have contributed to delays in developing the required training. Without appropriate training on reprocessing, VAMC staff may not be reprocessing RME correctly, which poses potential risks to the safety of veterans. VA headquarters officials told GAO that VA has plans to develop training for certain RME, but VA lacks a timeline for developing this training.

GAO also found weaknesses in VA's oversight of VAMCs' compliance with the selected purchasing and reprocessing requirements. These weaknesses render VA unable to systematically identify and address noncompliance with the requirements, which poses potential risks to the safety of veterans. GAO did not identify weaknesses in VA's oversight of VAMCs' compliance with the selected tracking requirements. GAO found the following:

- Oversight over purchasing requirements. In general, VA does not oversee VAMCs' compliance with the selected purchasing requirements. While VA intends to improve oversight over these requirements, it has not yet developed a plan for doing so.
- Oversight over reprocessing requirements. Although VA headquarters
 receives information from the VISNs on any noncompliance they identify
 as well as VAMCs' corrective action plans to address this noncompliance,
 VA headquarters does not analyze this information to inform its oversight.
 According to VA headquarters officials, VA intends to develop a plan for
 analyzing this information to systematically identify areas of
 noncompliance that occur frequently, pose high risks to veterans' safety,
 or have not been addressed across all VAMCs.