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STATEMENT OF
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BEFORE THE
SUBCOMMITTEE ON SPECIAL INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ON
CONTROLS OVER DRUGS IN VETERANS ADMINISTRATION MEDICAL CENTERS

Mr. Chairman and Members of the Subcommittee, we are pleased to be here today to discuss our recently issued report 1/ on controls over drugs in Veterans Administration (VA) Medical Centers. As you know, we issued a report 2/ to the Congress in September 1975 on the effectiveness of the pharmacy systems used in VA Medical Centers. In our 1975 report we stated that substantial drug losses in VA centers could be reduced and patient care improved by converting from the ward stock pharmacy system to unit dose--an improved system which provides better drug controls.

1/"Reassessment Of Veterans Administration's Controls Over Drugs: Million-Dollar Problem Still Exists" (HRD-80-86, June 24, 1980).

2/"Potentially Dangerous Drugs Missing in VA Hospitals--Different Pharmacy System Needed"(MWD-75-103, September 30, 1975).

Recognizing that it may not be economically feasible to convert all medical centers to the unit dose system in a short period of time, we made recommendations to VA that focused on interim actions that should be taken to improve and strengthen drug controls under the ward stock system. We also recommended that VA establish a definite timetable for VA-wide conversion of ward stock centers to the unit dose system. VA generally agreed with our recommendations and indicated it would implement them.

In June 1980, we issued a report on a followup review of actions that have been taken on our 1975 recommendations. This followup review was requested by you in a letter dated April 18, 1979, in which you indicated that the Subcommittee had received allegations of serious drug security problems at the Cleveland, Ohio, VA Medical Center. Our followup was performed at six VA medical centers which used the ward stock pharmacy system. VA Central Office pharmacy officials told us that these centers were typical of ward stock centers.

FINDINGS OF PRIOR REPORT

In our 1975 study, we reviewed both types of pharmacy systems at 11 VA medical centers--9 ward stock and 2 unit dose centers. We found that large quantities of the drugs we tested--24 to 57 percent of those withdrawn from stock--were missing at the nine ward stock centers. By contrast, 9 to 12 percent of the drugs tested at the 2 unit dose centers were unaccounted for. From our sample, we estimated that, in fiscal year 1974, as many

as 1.1 million tablets and capsules, or 43 percent of those withdrawn from stock, could have been unaccountably missing at the nine ward stock centers. The two unit dose centers, on the other hand, had about 30,000 tablets and capsules--about 11 percent of the selected drugs--estimated to be missing.

To strengthen controls over drugs at ward stock centers, we recommended that these centers:

--Establish and enforce a ward stock quota system to reduce quantities of drugs kept in the wards.

--Maintain adequate records of drugs ordered by and delivered to the wards.

--Reconcile all order and receipt discrepancies.

--Designate not more than two nurses--one to be an alternate--on each ward to be responsible for maintaining ward stock quota levels and ordering from the pharmacy when necessary.

--Monitor drugs dispensed by periodically reviewing pharmacy and warehouse receipts and deliveries and ward stock quota levels.

--Establish periodic test procedures similar to those we used in our 1975 review.

RESULTS OF FOLLOWUP REVIEW

Although it has been over 4 years since we first reported on shortcomings in VA's pharmacy systems, VA still does not have an effective program for controlling the use of, or accounting for, drugs dispensed at its ward stock centers. With

few exceptions, we found that the recommendations we made in 1975 were not implemented by VA at the ward stock centers reviewed.

Actions taken by VA

After our 1975 report, VA's Department of Medicine and Surgery issued four directives to all VA medical centers citing interim measures to strengthen drug controls. Two of these directives issued in April 1976 incorporated our 1975 recommendations.

Our followup showed that, while the directives had been received at each of the six centers we reviewed, little effort was made to put these policies and procedures into effect. As a result, the same internal control weaknesses we previously identified, continued to exist.

THE CLEVELAND MEDICAL CENTER--
A CASE STUDY

To illustrate the types of internal control problems existing at ward stock centers, our followup report focused on the pharmacy operations at the Cleveland VA Medical Center, which includes the Brecksville and Wade Park Divisions. At this center our followup showed there was no adequate system of drug controls through the maintenance of records, monitoring of drug use, and audit of drug receipts and deliveries. With minor exceptions, we found that the same basic internal drug control weaknesses also existed at the other five centers we reviewed.

Drug ordering procedures

In our followup review, we found that the drug ordering procedures at the Cleveland center provided limited means to verify what was ordered against what was received.

We found that the interim control measures we recommended were delineated in the April 1976 VA Central Office directives, and required that (1) drug orders prepared by nurses be completed in triplicate, (2) the nurses keep one copy and send two to the pharmacy, and (3) the pharmacy retain a copy and send the original back to the nurses with the drugs. The nurses were to verify drugs received against the copy and send only the completed order form back to the pharmacy. In addition, each ward was to maintain an active file of completed drug orders for potential review.

These procedures were not being followed at the Cleveland center. When ordering drugs, most wards at both facilities did not complete orders in triplicate or keep duplicate copies of pharmacy order forms, as required. In some instances orders were completed in single copy. As a result, the pharmacy copy when signed as "received," was generally the only documentation available to indicate that drugs were actually received in the wards.

VA's April 1976 interim control directives specifically assigned the responsibility of ordering drugs to only head nurses and their designated alternates. However, at the Cleveland center we found that any nurse or pharmacy technician could order drugs.

At the Brecksville division, no single procedure existed for ordering drugs. Ward stocks of drugs are maintained through both automatic stock replenishment and drug orders completed by ward nurses on VA pharmacy order forms. Under the automatic replenishment system at Brecksville, ward personnel leave empty bottles outside medicine cabinets and pharmacy technicians replace them with full ones. After replacing the empty bottles, the pharmacy technician servicing the ward completes a VA pharmacy order form for the drugs and signs it "Automatic Stock Replenishment." Other drugs ordered by ward nurses are picked up from the pharmacy by ward personnel.

At the Wade Park division, we found that drugs such as stimulants and depressants are usually ordered from the pharmacy by ward nurses on a VA pharmacy order form overprinted with the drug name. The pharmacy fills the order and the drugs are either delivered to the ward or picked up by nurses or other personnel. Also, controlled drugs 1/ other than schedule II drugs are sometimes automatically replenished by pharmacy personnel.

Because of the drug ordering procedures used at the Cleveland center, it was impossible for us to (1) reconcile discrepancies between the pharmacy and the wards, (2) establish

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1/The Drug Enforcement Administration (DEA) classifies certain drugs (both narcotic and nonnarcotic) that have the potential for abuse and/or addiction into five control classes. Schedule I drugs have the highest potential for abuse and Schedule V the least. Schedule I drugs have no medical use in treatment and are not available in hospitals.

responsibility for drug losses, or (3) accurately account for drugs dispensed.

Lack of control and accountability

At the Cleveland center, we found that orders for frequently abused drugs, such as Valium and Librium are often made, filled, and delivered to the wards by the same individual. We also found that pharmacy orders are frequently not signed by the drug orderer or receiver. For example, our analysis of completed pharmacy orders at Brecksville for controlled drugs dispensed during July 1979 showed that for 72 percent of the drugs dispensed orders were not signed by an acknowledged receiver. About one-fourth of Brecksville's pharmacy orders for controlled drugs were automatically replenished and signed only by the pharmacy technician who initiated the orders, filled them, and delivered them to the wards.

A similar situation also existed at Wade Park. At that center, we identified one possible fraudulent pharmacy order. The receiver's signature on this order for 60 units of Dalmane 30 mg.--a controlled substance--could not be traced to anyone on the wards.

Ward stock quotas

Contrary to VA's April 1976 directives which called for the establishment and enforcement of a ward stock quota system, we found no quotas in effect at either division of the Cleveland center.

According to one pharmacy official at the Cleveland center, attempts were made to establish quotas immediately after the April 1976 directives were issued; however, they proved unsuccessful. This official told us that quota levels for drugs by ward were tested; however, we found no test results, proposed forms, quota sheets, or other data to document these actions. Another pharmacy official told us that the required efforts to establish drug quotas were discontinued because the nursing service and pharmacy service could not arrive at a workable set of quotas. As a result, local pharmacy management concluded that established quotas were unmanageable and not responsive to changes and reorganization occurring in the wards.

Monitoring of drug dispensing and utilization

VA's Pharmacy Manual requires local pharmacies to document and maintain monthly ward inspections of all areas of the medical centers where drugs are used and report any discrepancies. These inspections are to include (1) reviews of patient charts and medication administration records to verify the need for keeping various drugs on the wards, (2) comparisons of drug medication orders with drugs dispensed, and (3) reviews of the volume of drugs sent to individual nursing units.

Our followup review showed that the Cleveland center was not adequately monitoring drug dispensing and utilization. We found that no effort was made to correlate drug receipts and

deliveries with actual (gross) drug use or reconcile pharmacy ward orders with actual drug administration in the wards.

Internal audit review system

In our 1975 report we recommended that ward stock centers maintain adequate records of drugs ordered and delivered to the wards. In addition, VA's April 1976 directives required each center to provide an internal audit review system to periodically review files maintained by pharmacy, nursing, and supply services.

During our followup, we found that there was no functional audit review committee at the Cleveland center. Although the Cleveland center purchases annually thousands of controlled drugs, we found no audits of records, receipts, or deliveries of these drugs.

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In our June 1980 report, we stated that our prior recommendations that were specifically aimed at eliminating weak drug controls in ward stock centers were still valid. We recommended that VA take immediate steps to implement them.

COMPLIANCE WITH PRESCRIPTION CONTROLS

Closely related to the drug control weaknesses previously discussed, our June 1980 report stated that a high percentage of the prescriptions filled at the six centers reviewed were incomplete or improperly prepared. In addition, we found that unused prescription pads were readily accessible to unauthorized persons and a number of physician signature cards were incomplete or outdated. We reported that given these conditions, the chance of

improper use of drugs is great and difficult to detect. We therefore recommended that VA take steps to strengthen compliance with prescription controls and improve security over unused prescription pads.

STATUS OF UNIT DOSE CONVERSION

Since our September 1975 report, VA has made some progress in converting its ward stock systems to unit dose. In our followup report we stated that VA has increased the number of unit dose medical centers from 7 at the time of our 1975 review to 45 centers. However, a more relevant measure of unit dose coverage is units of drugs dispensed. For example, in 1976 about 6 percent of all drugs dispensed to VA medical center patients were through a unit dose system. By 1979 this had increased to 16 percent. Thus, 84 percent of all drugs provided to medical center patients were dispensed by ward stock systems in 1979.

Studies on conversion benefits

After our 1975 report, two studies--one a VA contracted study and the other an internal VA study--showed that conversion to the unit dose system would be cost-beneficial.

The contracted study was completed in October 1977. In that study, the contractor's review of 5 ward stock and 5 unit dose centers showed a 2 to 1 benefit ratio in favor of unit dose. According to the study, net benefits of $14 million over a 25-year period would be achieved if the 5 ward stock centers were converted to unit dose. However, the report noted that, to convert the 5 centers to unit dose would require a substantial outlay of initial capital plus a projected increase in recurring budget costs.

According to the report, this outlay would be offset, to some extent, by reduced nursing time. Also, medication costs would be substantially reduced under the unit dose system as a result of decreased medication errors.

In addition to the contract study, the Pharmacy Service at VA Central Office prepared an analysis of unit dose conversion. In this study, two centers were compared before and after conversion. One center had 303 beds and the other had 757 beds. VA's analysis showed that one-time inventory savings were $13,868 at the smaller center and $43,980 at the larger center. Overall, the conversion to unit dose resulted in combined annual savings at both centers of about $575,000. In addition to the drug cost savings, VA's analysis showed savings in nursing and clerical staff and fewer medication errors.

Conversion timetable

In our 1975 report we recommended that VA establish a definite timetable for VA-wide conversion to unit dose. Our followup showed that since that time VA has established several timetables for conversion to unit dose.

In June 1979 VA took the position that all new and replacement centers would be constructed with unit dose pharmacy systems. For existing centers, conversion to unit dose depends on the willingness of the center directors to redirect staffing and funding for this purpose.

In our followup report we noted that no conversions to unit dose have been funded by VA Central Office since fiscal year 1978.

However, 12 additional medical centers are converting to unit dose using medical center funds. Thus, at the end of fiscal year 1979, 57 of the 172 VA medical centers (33 percent) have either partially or totally converted to unit dose.

According to a May 1980 report prepared by VA's Inspector General, VA's annual drug losses from ward stock systems were estimated to be about $16.4 million. In contrast, VA's annual drug losses from unit dose systems were estimated to be about $1 million, according to the IG's report. The IG concluded that VA could significantly reduce inpatient medication losses and medication errors by complete conversion to unit dose.

We believe that without specific funding, local center directors will be hard pressed to convert existing ward stock pharmacy systems to unit dose. In our followup report we recommended that VA identify the amount of funding necessary to permit systemwide conversion to unit dose and provide the resources required to the affected centers to achieve total conversion. We understand that at your request VA is now developing cost estimates for converting all ward stock centers to unit dose.

AGENCY COMMENTS

We discussed the report contents with Pharmacy Service officials at the VA Central Office and responsible center officials. Central Office officials generally agreed with the thrust of the report and its conclusions and recommendations. They said that a lack of funding and staffing resources was the primary reason for VA's slow progress in converting to the unit dose

system. Also, we were told that Central Office had not taken steps to evaluate the extent of medical center compliance with the required interim control measures. They said that the service has no authority to enforce the centers' compliance with required drug control procedures and that such authority primarily rests with management at the local level. At the Center level, some officials believed that added personnel were necessary to implement the interim controls. Others said that, due to increasing pharmacy workloads, it would have been hard to put the required controls into effect.

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Mr. Chairman, this concludes my statement. We will be happy to respond to any questions you or members of the Subcommittee may have.