



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

## **News Release**

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FOR IMMEDIATE RELEASE  
April 12, 2017

### **Inventory Management and Staffing Deficiencies at the Washington, DC, VA Medical Center That Are Placing Patients at Unnecessary Risk**

WASHINGTON – The VA Office of Inspector General (OIG) issued an [Interim Summary Report](#) on inventory management practices and staffing deficiencies that place patients at unnecessary risk at the Washington, DC, VA Medical Center (VAMC). OIG deployed its Rapid Response Team to the VAMC on March 29, 2017 to investigate the matter.

The OIG has preliminarily identified a number of serious and troubling deficiencies at the VAMC that place patients at unnecessary risk. Although we have not identified any adverse patient outcomes at this time, we found, among other issues, that:

- there was no effective inventory system for managing the availability of medical equipment and supplies used for patient care;
- there was no effective system to ensure that supplies and equipment that were subject to patient safety recalls were not used on patients;
- 18 of the 25 sterile satellite storage areas for supplies were dirty;
- over \$150 million of equipment or supplies had not been inventoried in the past year and therefore had not be accounted for;
- a large warehouse stocked full of non-inventoried equipment, materials and supplies has a lease expiring on April 30, 2017, with no effective plan to move the contents of the warehouse by that date; and
- there are numerous and critical open senior staff positions that will make prompt remediation of these issues very challenging.

Although our work is continuing, we believed it important to publish this Interim Summary Report given the exigent nature of the issues we have preliminarily identified and the lack of confidence in VHA to adequately and timely fix the root causes of these issues. At least some of these issues have been known to the Veterans Health Administration senior management for some time without effective remediation. We also included recommendations for immediate implementation.

“OIG became aware of potentially serious patient care issues at the Washington, DC, Medical Center and promptly deployed our Rapid Response Team to investigate,” said Michael J. Missal, Inspector General, U.S. Department of Veterans Affairs, Office of Inspector General. “Part of OIG’s mission is to monitor the quality of patient care and outcomes for veteran patients who rely on VA for their health care. When we become aware of deficiencies at VA that place patients at unnecessary risk, we will act immediately and aggressively to address those deficiencies.”

OIG notified VA of its initial findings on March 30, 2017. VA did take several immediate actions to address the issues such as establishing an incident command center, temporarily assigning an additional logistics chief, technicians, and Veterans Integrated Service Network staff to the facility on a temporary basis. OIG feels that these actions are short-term and insufficient to ensure the implementation of an effective inventory management system at the VAMC. Shortages of medical equipment and supplies continued to occur while our OIG team was onsite, confirming that correcting the problems is going to require a coordinated long-term effort by VA.

OIG’s review of these issues is continuing and we will provide a final comprehensive report after our work is completed. OIG’s Rapid Response Team is a new initiative that provides a team that can be quickly deployed to address high-risk/high priority cases, events, or system failures in VA facilities or programs.

The VA OIG conducts oversight of VA and its programs and operations, providing independent and objective reporting to the VA Secretary and the Congress for the purpose of preventing and detecting fraud, waste, and abuse, and bringing about positive change in the integrity, efficiency, and effectiveness of VA. To report potential criminal activity, fraud, waste, mismanagement, or other abuse, contact the VA OIG Hotline at [vaoi hotline@va.gov](mailto:vaoi hotline@va.gov) or [www.va.gov/oig/hotline/default.asp](http://www.va.gov/oig/hotline/default.asp).

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