SUPPLY CHAIN INVENTORY MANAGEMENT

1. REASON FOR ISSUE: This Veterans Health Administration (VHA) directive provides policy, mandatory procedures, and operational requirements for implementing an effective VHA supply chain management (SCM) program at medical facilities within the Department of Veterans Affairs (VA).

2. SUMMARY OF CONTENT: This directive issues policy on the roles and responsibilities for implementing an effective supply chain management program at VA medical facilities. Major changes include:

a. Recommendations have been added from the VHA Office of Business Oversight for facility Expendable Item Management reviews.

b. Responsibilities have been added for Prosthetics and Sensory Aids Service, and for the Veterans Integrated Service Network (VISN) Chief Logistics Officer (CLO) and Facility Chief Logistics Officer (FCLO) to work with the network Director of Contracting (DOC).

c. Requirements have been added for the establishment of a Network Commodity Standardization Committee (NCSC) and facility Clinical Product Review Committee (CPRC).

d. Requirements have been added for maintaining Item Master File and Vendor File Edit Access Lists.

e. Removed requirement for Posted Stock per Deputy Under Secretary for Health for Operations and Management Memo, dated January 02, 2009.

f. Requirements have been updated on the use of mandatory categories, ## inventory points, and consignment inventories. Requirements have also been updated for the completion of mandatory fields in primary inventory points.

g. Requirements have been added for the barcode scanner program PRCUS when conducting an inventory of stand-alone primaries as well as for barcode label minimum requirements.

h. Requirements have been updated for conducting a physical inventory count audit of expendable supply items and reviewing inventory management system reports on a minimum review frequency.

i. Requirements have been added for clean/sterile, environmental, and engineering primary and secondary inventory points.

j. Requirements have been added for the transportation of clean/sterile expendable items to another building and/or facility.

k. Requirements have been updated for employee development and training.

l. Requirement has been updated for Consolidated Mail Outpatient Pharmacy inventories to have a ≥ 36.50 turnover rate.

m. Pharmacy requirements have been added for compliance with the Drug Supply Chain Security Act (DSCSA).

3. RESPONSIBLE OFFICE: The VHA Procurement & Logistics Office (10NA2) is responsible for the content of this directive. Questions may be addressed to VHALogisticsOperationTeam10NA2@va.gov.

4. RELATED ISSUE: None.

5. RESCISSIONS: VHA Handbook 1761.02, dated October 20, 2009, is rescinded.

6. RECERTIFICATION: This VHA directive is scheduled for recertification on or before the last working day of October 2021. This VHA directive will continue to serve as national VHA policy until it is recertified or rescinded.

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Under Secretary for Health

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1. PURPOSE

This Veterans Health Administration (VHA) directive provides policy, mandatory procedures, and operational requirements for implementing an effective supply chain management (SCM) program at Department of Veterans Affairs (VA) medical facilities, Community Based Outpatient Clinics (CBOCs)/Outpatient Clinics (OPCs), and Consolidated Mail Outpatient Pharmacies (CMOPs). **AUTHORITY:** 38 U.S.C. 8121, 8215.

2. BACKGROUND

a. The Generic Inventory Package (GIP) is the current software being utilized for inventory management of stock.

b. Details provided in this directive and in related Inventory Management Standard Operating Procedures (SOPs), are at times specific to GIP. Subsequent amendments to these documents will be issued to address any GIP replacement software. Updated information will be available at: http://vaww.pclo.infoshare.va.gov/PCLO/default.aspx. *NOTE: This is an internal VA Web site that is not available to the public.*

c. The Government Accountability Office (GAO) report number 11-391, *VA Health Care Weaknesses in Policies and Oversight Governing Medical Supplies and Equipment Pose Risks to Veterans' Safety*, dated May 2011, and report number 13-336, *Veterans Health Care VHA Has Taken Steps to Address Deficiencies in Its Logistics Program, but Significant Concerns Still Remain*, dated April 2013, recommended that VA take steps to:

(1) Require medical facilities to enter information about all expendable medical supplies into an inventory management system.

(2) Ensure that logistics staff, rather than clinical staff manage all medical supplies.

(3) Ensure that all medical supplies and reusable medical equipment (RME) purchased by medical facilities are captured on a list of approved items for use at the facility.

(4) Enter all stock surgical and dental instruments into the appropriate inventory management system.

(5) Develop a formal process for reviewing and approving emergency purchases of medical supplies and RME.

d. The VA Office of Inspector General (OIG) report number 11-00312-127, *VHA Audit of Prosthetics Supply Inventory Management*, dated March 30, 2012, recommended that VA take steps to:

    (1) Ensure that the physical inventory count of stocked supplies match the inventory system on hand value, eliminate excess inventory, and purchase supplies to avoid identified shortages.

    (2) Develop a plan to replace the Prosthetics Inventory Package and Generic Inventory Package with a comprehensive modern inventory management system.

    (3) Require at least one prosthetic supply inventory manager from each VA medical facility to attend an inventory management class at the VA Acquisition Academy.

    (4) Eliminate exemption related to compliance with maximum stock levels; establish normal, reorder, and emergency stock levels; and recording supply receipts and usage in an automated inventory management system.

    e.   The VHA Office of Business Oversight (OBO) performs ongoing Logistics Business Reviews (LBR) of VHA Medical Center Inventory Management programs. The report number 14-02-LOG-NR-001, OBO LBR Summary, dated January 07, 2015, made the following recommendations for expendable item management:

    (1) Improve the accuracy rate of inventory on hand and the retention of physical inventory documentation.

    (2) Review inventory reports on a scheduled basis to manage stock levels and ensure accuracy of information.

    (3) Review on-demand items (ODI) to determine if items should be maintained with this classification, converted to a standard item, or removed from inventory.

    (4) Ensure barcode labels are utilized to identify all items within primary and secondary inventory point storerooms.

NOTE: Based on the recommendations made by the GAO, OIG, and OBO, operational requirements have been added to this directive.

    f.   If VA replaces its core automated financial and logistics management systems, the new system(s) is expected to draw historical and operational data from existing VA automated systems. Therefore, a national supply chain management program ensuring accurate and consistent data in a populated database is necessary for a smooth conversion.

3. DEFINITIONS

    a. **Bulk Storeroom.** A bulk storeroom is a storage area, usually in a warehouse, where supplies and equipment are kept in large quantities in their original shipping containers.

    b. **Central Storeroom.** A central storeroom is the area which stores and distributes clean/sterile medical supplies and equipment for use throughout the medical facility.

c. **Clean/Sterile Storeroom.** A clean/sterile storeroom is a primary or secondary inventory point location where clinical items are stored to protect them from accidental contamination.

d. **Clinical Items.** Clinical items are non-durable disposable health care materials ordered or prescribed, which are primarily and customarily used to serve a medical purpose. Within VHA, items with the following Federal Supply Classification (FSC) codes are identified as meeting this definition.

(1) 6508 Medicated Cosmetics and Toiletries.

(2) 6510 Surgical Dressing Materials.

(3) 6515 Medical and Surgical Instruments, Equipment, and Supplies.

(4) 6520 Dental Instruments, Equipment, and Supplies.

(5) 6525 X-ray Equipment and Supplies - Medical, Dental, and Veterinary.

(6) 6530 Hospital Furniture, Equipment, Utensils, and Supplies.

(7) 6532 Hospital and Surgical Clothing and Related Special Purpose Items.

(8) 6540 Ophthalmic Instruments, Equipment, and Supplies.

(9) 6545 Replenishable Field Medical Sets, Kits, and Outfits.

(10) 6550 Invitro Diagnostic Substances, Reagents, Test Kits, and Sets.

(11) 6640 Laboratory Equipment and Supplies.

e. **Consignment.** Consignment is placing an item in the hands of another while retaining ownership.

f. **Corrugated.** Corrugated is packaging made of paper or plastic that has an arched layer, called "fluting," between smooth sheets, called "liners."

g. **Direct Patient Care.** Direct patient care is hands-on, face-to-face contact with patients using expendable clinical items and reusable medical equipment (RME) for the purpose of diagnosis, treatment, and monitoring.

h. **Environment of Care.** Environment of care means to plan, implement, and evaluate programs to support the safety and security functions within the medical facility and grounds. Coordinate safety activities within the organization. Oversee activities of committees such as the Radiation Safety Committee (Nuclear Regulatory Commission and VHA requirements), Laser Safety, etc. Oversee performance improvement activities in Safety. Assess compliance with accrediting bodies (The Joint Commission, The Commission of Accreditation of Rehabilitation Facilities (CARF), proposes solutions and/or improvements, and monitors implementation and effectiveness.

    i.   **Expendable Supplies.** Expendable supplies are disposable, commodity items that are typically used one time.

    j.   **Generic Inventory Package.** The GIP portion of Integrated Funds Distribution, Control Point Activity, Accounting and Procurement (IFCAP) is used to manage the receipt, distribution, and maintenance of supplies utilized throughout the Department of Veterans Affairs (VA) medical facility.

    k.   **Integrated Funds Distribution, Control Point Activity, Accounting and Procurement.** IFCAP is a software system that provides information on supplies, equipment, vendors, procurement history, and control point activity.

    l.   **Item Master File.** The IMF is a file within the Veterans Health Information Systems and Technology Architecture (VistA) IFCAP software program utilized for the storage of item information to include item description, mandatory source, vendor, unit price and packaging, and product and manufacturer information. This file links with the request and procurement files and provides for the extraction of item procurement history. This allows for a consistent inventory system and common source for data to support the VHA Standardization Program, the National Procurement History File, and fully automate the management of all unofficial inventories.

    m.   **Inventory Point Identifier.** The IE is an internal system identifier for the inventory point that is automatically assigned when the inventory point is created.

    n.   **Ordering Officer Delegation.** The Ordering Officer Delegation (OOD) is a written delegation from a warranted Contracting Officer that allows a non-warranted individual to place funded delivery/task orders against a specific indefinite delivery contract within the limitations of the contract and the ordering officer delegation memorandum. A Contracting Officer can only issue ordering officer delegations against contracts they have awarded or contracts that have been officially transferred to them to administer.

    o.   **Point-of-Use Solution(s).** POU is the employment of a combination of automated supply stations (POU equipment) and POU systems that streamline the supply chain for timely delivery of required supplies to the point where those supplies are consumed.

    p.   **Personal Protective Equipment.** PPE is protective equipment, such as approved head and hair coverings, face shields, safety glasses/goggles, long cuffed rubber/vinyl decontamination gloves, impervious gowns, and shoe covers that are utilized to protect the employee from the environment.

    q.   **Reusable Medical Equipment.** RME is medical equipment designed by the manufacturer to be reused with multiple patients.

    r.   **Real Time Location System.** A RTLS gathers and maintains location-based (and sometimes status) information related to components of a larger system (e.g. healthcare-related assets, supplies, people).

s. **Safety Data Sheet.** The Safety Data Sheet (SDS) is a document containing information on hazardous materials from the manufacturer to the employer and/or user. A SDS includes information such as: product and manufacturer identification, hazard(s) identification, composition/information on ingredients, first-aid measures, fire-fighting measures, accidental release measures, handling and storage, exposure controls/personal protection, physical and chemical properties, stability and reactivity, toxicological information, ecological information, disposal considerations, transport information, and regulatory information.

t. **Supply Chain Management.** SCM is the integration and alignment of people, processes, and systems across the supply chain to manage all product/service planning, sourcing, purchasing, delivering, receiving, and disposal activities.

u. **Total Supply Support.** TSS is management methods, practices, and procedures employed in determining goods and services requirements, and their funding acquisition, receipt, storage, issuance, and final disposition.

4. POLICY

It is VHA policy that VA medical facilities establish, operate, and maintain a SCM program that is effective, cost efficient, transparent, and responsive to customer requirements. A framework for SCM practices is provided for strategic planning, sourcing and procurement, distribution, and inventory management. VA medical facilities are required to implement and follow all policies and procedures in this directive as well as continually identify ways to improve SCM performance in support of high-quality Veteran care.

5. RESPONSIBILITIES

a. **VHA Procurement and Logistics Office.** The VHA Procurement and Logistics Office (P&LO) is responsible for:

(1) Establishing a supply chain management program within VHA. This office provides policy and procedures, collects and manages data, performs quality assurance, and implements tools for corrective action. In addition, the P&LO provides staff opportunities for education, training, and certification programs.

(2) Serving as a SCM liaison between Veterans Integrated Service Networks (VISN), VHA Central Office, and the Office of Acquisition Logistics and Construction (OAL&C).

(3) Providing oversight for Prosthetics and Sensory Aids Service (PSAS) supply inventories to include setting policies and procedures, and performance measures. Monitoring performance to ensure that established goals are achieved, regardless of the inventory system utilized or the program office assigned responsibility for management of these supplies.

b. **VHA P&LO Program Executive Office.** The P&LO Program Executive Office (PEO) is responsible for:

(1) Leading national standardization efforts for supplies and equipment. Items will be standardized to the greatest extent possible, which are consistent with patient care and practitioner needs. These items will be identified as VHA standard items and will be mandatory for use at all VA facilities. Standardizing items will help to maximize best-value pricing through volume purchasing and facilitate the delivery of high-quality health care.

(2) Establishing teams to manage national standardization efforts post award and forming integrated product teams (IPT) to handle pre-procurement efforts. Teams will develop technical requirements, discuss risks and mitigation strategies, determine the optimal acquisition strategy, set acquisition milestones, and ensure effective life cycle acquisition, contract, and performance management. The recommendations of the team will be shared with the Business Owner for approval prior to being sent to contracting for solicitation and award.

(3) Communicating and prioritizing standardization efforts being worked on with the field based on the greatest potential for dollar savings.

(4) Sharing VISN recommendations for items that may be appropriate for national standardization with appropriate Business Owners to determine if these items can be standardized.

(5) Reviewing and approving requests for waivers from use of nationally standardized items.

c. **VHA Prosthetics and Sensory Aids Service.** The VHA Prosthetics and Sensory Aids Service (PSAS) is responsible for:

(1) Complying with SCM policies and procedures identified within this directive to effectively manage PSAS items.

(2) Sharing PSAS policy and procedures with logistics that are applicable to SCM functions and identifying ways to consolidate where possible.

(3) Collaborating with logistics to eliminate redundancies in contract requirements.

d. **Veterans Integrated Service Network Director.** The VISN Director is responsible for:

(1) Ensuring that a VISN level SCM program is established that effectively meets policy, reporting, and operational requirements.

(2) Ensuring that VHA SCM performance standards are met by VISN medical facilities.

(3) Ensuring that the purchase of clinical items using a government purchase card is limited to staff in Logistics, the Network Contracting Office (NCO), Pharmacy, and PSAS.

    e. **VISN Chief Logistics Officer.** The VISN CLO is responsible for:

    (1) Representing the VISN on all topics related to SCM; serving on boards, committees, councils, and teams at the VISN and national level; facilitating communication between medical facilities, VISNs, and VHA Central Office; and developing and implementing VISN strategies to improve SCM programs.

    (2) Working with clinical groups to meet patient care needs while also seeking ways to achieve supply chain goals.

    (3) Assisting with the formulation of VHA SCM policies and procedures.

    (a) Establishing a VISN-wide Outlook Email group that includes all SCM employees, entitled "VISN __ Supply Chain Management."

    (b) Establishing communication with VA medical facilities to effectively implement SCM policy, reporting, training, and operational requirements.

    (4) Identifying VA medical facility staff members who manage and perform SCM duties regardless of where they are organizationally aligned and ensuring that these staff and their leadership are aware of training opportunities.

    (5) Assessing inventory management programs at VISN medical facilities through a quality control review once per fiscal year.

    (6) Ensuring compliance with established VA and VHA directives, handbooks, memoranda, and notices.

    (7) Managing supply chain data in coordination with the Facility Chief Logistics Officer (FCLO).

    (a) Participating in the FCLO selection and annual performance evaluation process.

    (b) Scheduling network meetings, conferences, and trainings to discuss SCM topics.

    (c) Serving as the Network Recall Coordinator (NRC) in accordance with VHA Directive 1068, Recall of Defective Medical Devices and Medical Products Including Food and Food Products, or its successor.

    (d) Serving as the co-chair of the Network Commodity Standardization Council (NCSC) Board with the Network Chief Medical Officer or designee.

    (e) Collaborating with the network Director of Contracting (DOC) to establish a standardized communication method to track the status of all procurement packages sent to contracting within the VISN. In addition, working with the network DOC and other stakeholders to establish an acquisition plan for emergency preparedness.

    f. **VA Medical Facility Director.** The VA medical facility Director is responsible for:

(1) Ensuring that proper resources (i.e., space, staffing, and technology) are allocated to the facility SCM program to meet the requirements of this directive.

(2) Working with the FCLO to implement SCM initiatives that seek to optimize customer service outcomes.

(3) Establishing a regularly scheduled forum for medical facility leadership to discuss SCM performance with the FCLO.

g. **Facility Chief Logistics Officer.** The FCLO is responsible for:

(1) Representing facility leadership on all topics related to SCM and serves as the facility Accountable Official in accordance with VA Directive 7002, Logistics Management, or its successor.

(2) Establishing a local SCM program that meets policy and operational requirements. In addition, a Clinical Products Review Committee (CPRC) will be established to ensure that supplies are compatible with current processes and equipment prior to use within the medical facility.

(3) Submitting an action plan for inventory accounts not fully established to P&LO for approval, as defined in this directive.

(4) Completing a Logistics staffing level review as program responsibilities change.

(5) Promoting efficient utilization of supplies by ensuring that proper items and levels are set within inventory points.

(6) Ensuring SCM staff complete all mandatory education and training.

(7) Serving as the Facility Recall Coordinator (FRC) in accordance with VHA Directive 1068, Recall of Defective Medical Devices and Medical Products, Including Food and Food Products, or its successor.

(8) Working with the facility Chief Financial Officer (CFO) to address budgetary requirements, establish fund control parameters, and complete a year end certification letter for inventory values.

(9) Collecting information, responding to surveys, submitting nominations for training, serving as point-of-contact for Office of Inspector General (OIG) inquiries, coordinating visits by the VISN CLO, and other related activities.

(10) Establishing a Total Supply Support (TSS) program at the medical facility and utilizing a VHA-approved inventory management system to maintain automated inventories.

(11) Ensuring that the Logistics program completes a physical inventory (wall-to-wall or cycle count) of all items within primary inventories with distribution points once per

fiscal year. Exception: a physical inventory of ammunition must be completed on a semi-annual basis.

(12) Working with medical facility management to ensure that employees do not unacceptably convert VA property for personal use. For more guidance on this topic see 28 CFR 45.4 Personal Use of Government Property.

h. **Facility Pharmacy Program Manager.** The facility Pharmacy Program Manager is responsible for:

(1) Implementing the inventory management practices specified in this directive.

(2) Conducting a wall-to-wall physical inventory audit at medical facilities based on requirements specified by Pharmacy Benefits Management (PBM). Consolidated Mail Outpatient Pharmacy (CMOP) shall conduct wall-to-wall physical inventory audits on a quarterly basis.

6. REFERENCES

a. VA Directive and Handbook 7002 Logistics Management Procedures.

b. VA Handbook 7348 Utilization and Disposal of Personal Property.

c. VA Financial Policy Volume XVI, Chapter 01 Government Purchase Card Program.

d. VA Pandemic Influenza Plan (March 2006).

e. VHA Directive 1068 Recall of Defective Medical Devices and Medical Products Including Food and Food Products.

f. Materiel Handlers Training Guide TG-90-1.

g. VA PPM (2016-02) – VA Procedures Regarding the Use of Ordering Officers

SUPPLY CHAIN PROGRAM MANAGEMENT

1. REQUIREMENTS FOR SUPPLY CHAIN PROGRAM MANAGEMENT

   To ensure full implementation and oversee ongoing supply chain program management, the following steps must be taken to implement new inventories and maintain existing inventories:

   a. **Evaluating Staffing Levels.** Staffing levels must be evaluated to determine adequate requirements for compliance with this directive.

   b. **Physical Space Planning.** The plans for establishing an inventory storeroom must include careful consideration of space, climate control, availability of shelving, and frequency of users accessing inventory.

   (1) The inventory manager must consider the products being stored, the grouping of products used for a particular procedure or process, security requirements, criticality of the product, infection control requirements, environment of care requirements, and product availability from vendors and manufacturers. Successful implementation is dependent upon this analysis.

   (2) The inventory manager will involve the customer when establishing an inventory point storeroom. Failure to plan the layout of the inventory point storeroom with appropriate customer input could result in the wrong products being stocked and inappropriate levels being set.

   c. **Monitoring and Evaluating Inventory Accounts.**

   (1) Inventory account policies and decisions must be made based on local needs, economic investment in inventory, and the VA medical facility mission. Monitoring and evaluating inventory accounts requires maintaining two separate inventory categories: Clinical that includes all expendable clinical items, and Non-clinical that includes all expendable non-clinical items.

   (a) Monitoring inventory accounts involves identifying baseline achievement levels at each medical facility within the Veterans Integrated Service Network (VISN) and targeting potential new accounts to include maintaining two separate inventory categories: Clinical and Non-clinical. At a minimum, inventory points will be established under the two categories to monitor and evaluate the following types of expendable items:

   1. Dental

   2. Engineering

   3. Environmental

   4. Imaging

5. Laboratory

6. Medical Surgical

7. Prosthetics

NOTE: See Appendix C for a list of minimum Functional Areas Requiring Inventory Management. Pharmacy is exempt from this monitoring requirement.

(b) Action Plan. If it is determined that an inventory point is not implemented in accordance with this directive, an action plan must be prepared by the Facility Chief Logistics Officer (FCLO) and submitted through the Medical Center Director, VISN CLO, and Network Director for approval by the VHA P&LO. The P&LO has 30 calendar days to approve and return the plan to the Network Director. Upon receipt of the approved plan, the facility will proceed with implementation, to be completed within the timeframe stipulated by P&LO. If a response to the submitted action plan is not received from P&LO within 30 days, the plan is considered approved.

(c) Evaluation. Evaluating the supply chain management program includes the VISN CLO conducting an assessment of supply chain functions at each medical facility within the VISN to include:

1. An annual review of operational practices to ensure compliance with regulatory and performance measure requirements.

2. Analysis and assessment of VA medical facility needs.

3. Resources required for implementation (i.e., Information Technology (IT) equipment, scanners, etc.).

4. Training needs.

d. **Requirements for Performance Measures.**

(1) Performance measures will be released by VA and VHA on an ongoing basis to monitor SCM core activities and data accuracy. The following metrics represent minimum performance requirements that must be met for standard supply items.

Category	Days of Stock on Hand	% Inactive more than 90 Days	% Long Supply
Clinical (MSPV)	15	20	10
Clinical	30	20	10
Non-Clinical (EMS)	30	15	10
Non-Clinical (Engineering)	90	n/a	10

NOTE: Performance requirements for the Clinical (MSPV) category apply to items purchased through the MSPV contract.

(2) In the event of a natural disaster or emergency, a waiver may be requested by a VISN CLO for a facility to suspend logistics performance measures for a given period of time. A waiver must be sent to the P&LO within 14 business days of the given event. In cooperation with the VISN and the facility, P&LO will determine the amount of time that performance measures will be suspended.

e. **Customer Service Expectations.** The following customer service expectations must be addressed by all SCM staff:

(1) Availability (right product, right place, right time, and right condition)

(2) Cost (product and time requirements)

(3) Education

(4) Industry relationships

(5) Ongoing communications and customer involvement

(6) Quality (acceptable or required features for intended purpose)

(7) Responsiveness

(8) Timeliness

(9) Trust

(10) Support of clinical requirements and other programmatic needs

f. **Inventory Management and Standardization.** VA medical facilities shall manage all inventory points tracked under the two Mandatory Categories and ## primaries. A ## is used to identify a primary that should not be tracked within performance measures. In addition, all purchase transactions must reflect the Item Master File (IMF) number. This allows for a consistent inventory system with common data standards.

(1) There are standard reports available in the current inventory management system that are used at the VISN and National level; although, local unique reports may be developed.

(2) Users can identify inventory items that must be used or exchanged to facilitate introduction of standardized items.

(3) The inventory management system includes inventory point locations where items are stocked, which is helpful when planning new product in-service training.

(4) Inactive and long supply items must be properly stored, accounted for, and disposed of in accordance with VA Handbook 7348, Utilization and Disposal of Personal Property, or its successor. Inactive and long supply items may be transferable among facilities.

g. **Network Commodity Standardization Committee.** The VISN shall establish a Network Commodity Standardization Committee (NCSC) Board and at a minimum, the following sub-committees including Dental, Engineering, Environmental, Imaging, Lab, Medical/Surgical, and Sterile Processing Service (SPS)/Reusable Medical Equipment (RME). The Board and subcommittees are tasked with proposing, implementing, and reporting benefits realized (i.e. cost avoidance and performance improvement) and issues (i.e. quality and safety) as a result of VISN and medical facility commodity standardization. Results of reporting will be captured on a monthly basis by the NCSC Board for use to further improve operations.

(1) The NCSC Board shall include a cross section of business and clinical experts who have knowledge and experience with commodities proposed for implementation by the NCSC subcommittees.

(a) At a minimum, NCSC Board membership will include:

    1. VISN CLO (Co-Chair)

    2. Chief Medical Officer (or Designee) (Co-Chair)

    3. Network Director of Contracting (DOC)

    4. Facility Assistant or Associate Director

    5. Clinical Representative (Physician or Nurse) from each facility

    6. Finance

    7. Biomedical Engineering

    8. Office of Information and Technology (OI&T)

    9. Patient Safety

    10. Radiation Safety Officer (ad hoc)

(b) Specific responsibilities of the NCSC Board include:

    1. Prioritizing subcommittee commodity standardization projects for VISN implementation.

    2. Compiling, consolidating, and submitting ideas for national commodity standardization to the P&LO Program Executive Office (PEO).

3. Supporting P&LO PEO integrated product teams (IPT) commodity standardization efforts by offering clinical, technical, and business expertise as requested.

4. Facilitating the integrated management of clinical and business performance under established contract agreements.

(2) The NCSC subcommittees shall include a cross section of business and clinical experts who have knowledge and experience with commodities proposed for implementation by the subcommittee.

(a) At a minimum, NCSC subcommittee membership shall include:

1. FCLO (Co-Chair)

2. Clinician (Co-Chair)

3. Clinical Subject Matter Experts

4. Contracting Officer

5. Finance

6. Biomedical Engineering

7. OI&T

8. Patient Safety

(b) Specific responsibilities of the NCSC subcommittees include:

1. Engaging medical facility stakeholders in support of similar commodity standardization efforts.

2. Identifying opportunities for commodity standardization at the medical facility and VISN levels and reporting them to the NCSC Board.

3. Developing requirements packages for contracting personnel to establish consolidated contract agreements.

h. **Facility Clinical Product Review Committee.**

(1) The requirement of a facility Clinical Products Review Committee (CPRC) is applicable to all VHA clinical programs, except Non-human Research and Pharmacy who are responsible for tracking and managing the expendable clinical items of its programs. The CPRC at each medical facility is tasked with:

(a) <u>Reviewing and Approving.</u> Reviewing and approving all new expendable clinical items and RME prior to their use for direct patient care so that compatibility with current processes and equipment is ensured.

(b) <u>Commodity Standardization.</u> Performing commodity standardization activities listed below.

1. Identify opportunities for local standardization of expendable clinical items, to reduce the number, size, type, and grades of items necessary to meet VA program requirements while ensuring superior safety and efficacy.

2. Assure economical purchasing and distribution of expendable clinical items and RME.

3. Forward opportunities for standardization to the NCSC Board for consideration.

4. Ensure compliance with mandatory National Standardized Contracts, Blanket Purchase Agreements (BPA), and Basic Ordering Agreements (BOA).

NOTE: For locally/nationally standardized items, a CPRC review at the facility is still required to ensure staff training, processing, and other local issues are addressed appropriately.

5. Report all issues identified with item use related to product safety and/or efficacy.

(c) <u>Coordination of training.</u> Coordinate with the using service as well as clinical staff to ensure the expendable clinical item in-service training is made available to users.

(2) CPRC requests will follow one of two paths based on being classified as either a standard or emergency request.

(a) <u>Standard request.</u> The process for approving a new expendable clinical item consists of several steps as described below.

1. A VA employee (requestor) enters a request into the national electronic CPRC Request Portal and ensures that the question for, "Is this an emergency request?" is marked no.

2. The requestor's Service Chief reviews the request with options to reject, accept, or request more information before it is passed to the CPRC Chairperson

3. The Chairperson reviews the request with options to reject, accept, or request more information before it is forwarded to the CPRC Committee

4. First Vote - The CPRC Committee votes on whether the item should be trialed. A majority (51 percent) vote is necessary to accept/reject the item for trial.

5. Second Vote - After the trial, the CPRC Committee will vote whether or not to adopt the item based on the trial results. A majority (51%) vote is necessary to accept/reject the item for adoption.

6. The CPRC Committee makes the final decision on item adoption. This decision is considered final.

(b) Emergency requests. In situations where a true emergency exists and the approval timeline for standard requests is unacceptable, the approval process below shall be followed.

1. A VA employee (requestor) enters a request into the CPRC Request Portal. This request must ensure that the question for, "Is this an emergency request?" is marked yes. In addition, a justification must be entered to support the emergency request.

2. The requestor's Service Chief reviews the request with options to reject, accept, or request more information before it is passed to the CPRC Chairperson.

3. The Chairperson reviews the request with options to reject, accept, or request more information before it is forwarded to the FCLO.

4. The FCLO reviews the request with options to reject, accept, or request more information. An emergency request is not sent to the CPRC Committee.

(3) The following product information, at a minimum, shall be entered into the CPRC Request Portal.

(a) Product Name

(b) Description

(c) Vendor name

(d) Vendor stock / catalog number

(e) Manufacturer name

(f) Manufacturer stock / catalog number

(g) Price

(h) Does this replace or impact other items?

(i) Identify item by IMF# (required if (h) marked yes)

(j) Is training required?

(k) Justification / clinical benefit

(l) Description of current practice or technology

(4) At a minimum, membership of the CPRC Committee shall be composed of the individuals below.

(a) Facility Chief Logistics Officer (Co-Chair)

(b) Chief of Staff (or Designee) (Co-Chair)

(c) Chief of Sterile Processing Service

(d) Biomedical Engineering

(e) Surgery

(f) Imaging Service

(g) Infection Control

(h) Patient Care/Nursing Service

(i) Medicine

(j) Quality Management

(k) Patient Safety

(l) Pathology and Laboratory Management Service

(m)Environmental Management Service

(n) Pharmacy

(o) Prosthetics and Sensory Aids Service

(p) Human Research

NOTE: The medical facility director may appoint one person to act on behalf of more than one service. This will be accomplished through written delegation by name and held on file by the CPRC Chairperson.

i. **Total Supply Support.**

(1) The medical facility Logistics program shall manage all clinical items and non-production instruments with the exception of Pharmacy and Research items.

NOTE: *These requirements also prohibit clinical department staff from using purchase cards to purchase medical supplies.*

(2) Acceptable total supply support (TSS) budget/funding models include:

(a) Logistics program manages all clinical items and funding from a **single** fund control point (FCP) with sub-control points designated to track and account for items used to support each clinical program area (i.e. SPS, Operating Room, etc.).

(b) Logistics program manages all clinical items and funding utilizing a **shared** FCP between Logistics and the supported program, utilizing sub-control points to track the clinical items and services funded by the FCP.

(c) Logistics program manages all clinical items and funding, utilizing **separate** FCPs for each clinical program supported.

(3) When new products or responsibilities are transferred to the Logistics program from another program area, the associated funding and FTEE will transfer with it when applicable.

j.   **Office of Information & Technology and Finance Involvement.** The assistance of the Facility Chief Information Officer (FCIO) and the Chief Financial Officer (CFO) at each VA medical facility is necessary to implement and maintain the automated inventory system.

(1) The IT equipment and software requirements must be planned in coordination with the overall medical facility IT plan. OI&T is required to be informed of changing requirements, technology advancements, software releases, and replacement needs.

(2) The VISN CLO has the responsibility to work with the FCLO, or designee, and OI&T to ensure the proper assignment of menu options for SCM staff to enable them to efficiently and effectively perform inventory management duties.

(a) The inventory manager, supply technician, purchasing agent, control point clerk, etc., may all have access to different menus.

(b) The FCLO determines which menus are needed and works with OI&T to ensure menus are assigned to appropriate staff.

(3) The proper management of inventories saves resources; therefore, it is imperative that the CFO be involved during development of inventory management plans.

NOTE: *The CFO is charged with the overall management of financial resources and is interested in the data that becomes available through effective use of the VHA-approved inventory management system. The system can provide valuable support in efforts to improve fund control management.*

(4) The FCLO works with the accounting staff and OI&T to provide cost reports and budget projections to the local CFO and customers as needed.

NOTE: This exchange of information improves the value of the inventory management program and assists the CFO with budget decisions.

   k. **Requirements for Safety Data Sheets (SDS).**

   (1) Any new product procured from a manufacturer/distributor must include an SDS and label that is compliant with the Globally Harmonized System (GHS) and/or an updated SDS is provided with the first shipment after an SDS is updated.

   (2) A hard copy of the SDS's may be maintained at the medical facility in a binder that will be updated when new products are received. The binder will be cross-referenced by product/chemical trade name and manufacturer/distributor and can be printed or a backup from the electronic system in paragraph l.(3).

   (3) The medical facility will utilize the Center for Engineering & Occupational Safety and Health (CEOSH/10NA11) Web-based SDS/Chemical Inventory Service at http://vaww.ceosh.med.va.gov/ceosh/MSDS.shtml to maintain hazardous material inventories and associated SDS's. *NOTE: This is an internal VA Web site that is not available to the public.* The service is capable of providing hard copies, labels, reports, and electronic backups. When the medical facility provides access to SDS's electronically, they must ensure that:

   (a) The SDS for all hazardous materials handled and/or stored will be readily accessible to employees in their work areas.

   (b) The system of electronic access is part of the overall hazard communication program of the workplace.

   (c) The employees are trained in the use of these devices, including specific software. Training is available at http://vaww.ceosh.med.va.gov/01SDS/pages/documents/Training-Tier1Basic20150511.pdf. *NOTE: This is an internal VA Web site that is not available to the public.*

   (d) The employees are trained and able to obtain hard copies of the SDS, if needed. If an employee is unable to locate an SDS, submit requests per http://vaww.ceosh.med.va.gov/01SDS/pages/documents/HTG-SubmittingaRequest20141204.pdf. *NOTE: This is an internal VA Web site that is not available to the public.*

   (e) There is an adequate back-up system for readily accessible hazard information in the event of an emergency including power-outages, equipment failure, on-line access delays, etc. To create an electronic backup, follow http://vaww.ceosh.med.va.gov/01SDS/pages/documents/HTG-

InventoryBackup20140509_000.pdf. ***NOTE:*** *This is an internal VA Web site that is not available to the public.*

(f) In case of emergency, a local written procedure must be available to immediately provide emergency response personnel with hard copies of SDS.

NOTE: *All links within the SDS section connect to an internal VA Web site that is not available to the public.*

2. REQUIREMENTS FOR TRAINING PROGRAM

a. The VISN CLO has overall responsibility for training of Logistics staff in the VISN. The FCLO has responsibility for training of Logistics staff in the VAMC.

b. Each Logistics staff member should have a training plan and/or Individual Development Plan (IDP). This training plan and/or IDP should align with factors including, but not limited to, the employee's position requirements, development needs, local labor agreements, and national strategic initiatives. All training plans should include an annual review of this directive.

c. At least one staff member responsible for the management of prosthetics inventory for each VA medical facility will complete a course in inventory management principles. Course attendees are required to complete a biennial inventory management refresher training to maintain their acquired skill level. Course development, execution, and monitoring will be jointly developed and executed by VHA, the VA Office of Acquisition Logistics & Construction, and the VA Acquisition Academy (VAAA).

3. REQUIREMENTS FOR PROSTHETICS AND SENSORY AIDS SERVICE

The medical facility Logistics program is responsible for inventory management of PSAS clinical items. All PSAS clinical items must be loaded into the IMF and VHA-approved inventory management system.

4. REQUIREMENTS FOR NUTRITION AND FOOD SERVICE EXCEPTION

Inventory requirements for Nutrition and Food Service (N&FS) subsistence items are determined and fulfilled through the proprietary software provided by the Subsistence Prime Vendor Contractor used by all VA medical facilities.

REQUIREMENTS FOR INVENTORY MANAGEMENT

1. INTEGRATED FUNDS DISTRIBUTION, CONTROL POINT ACTIVITY, ACCOUNTING AND PROCUREMENT

The IFCAP system is used to manage the receipt, distribution, and stock maintenance of items. IFCAP provides information on supplies, vendors, procurement history, and control point activity. It is essential that this information be entered into the IFCAP system completely and correctly.

2. ITEM MASTER FILE PROCEDURES

a. The facility shall enter all expendable supplies into the IMF or successor system that are associated with the clinical and non-clinical categories, and ## primaries.

b. Expendable supplies purchased one or more times must be entered into the IMF.

c. Permissions to enter or modify data within the IMF is limited to four individuals at a level one facility and three individuals at level two and three facilities, with one being the FCLO. Facilities may submit a memo request to P&LO through the VISN CLO to temporarily increase the number of individuals with permissions to enter or modify data within the IMF. The request must include a justification and a start and end date for temporary access. The FCLO will maintain a Facility IMF Edit Access List of all individuals at the facility who have permissions to enter or modify data within the IMF. This list will be provided to the VISN CLO when changes are made and at least annually by October.

3. VENDOR FILE PROCEDURES

a. The vendor file is regulated by VHA P&LO and contains a list of vendors that can be used for acquisition or payment. Each facility is required to ensure the accuracy and completeness of information contained within this file.

b. Permissions to enter or modify data within the vendor file will be limited to facility staff in Logistics, Prosthetics and Sensory Aids Service (PSAS), and fiscal. A minimum of one employee from each of the three areas is recommended to have this level of access. The FCLO will maintain a Facility Vendor File Edit Access List of all individuals at the facility who have permissions to enter or modify data within the vendor file. This list will be provided to the VISN CLO when changes are made and at least annually by October.

4. GENERIC INVENTORY PACKAGE

a. The IFCAP GIP system, as of the writing of this directive, is still the official expendable inventory management system of record at VA medical facilities. The facility shall enter all expendable supplies into GIP or successor system that are associated with the clinical and non-clinical categories, and ## primaries. The main

functions of this system are to track the receipt and distribution of supplies. Medical facilities may utilize RTLS to track inventory of Cardiac Catheterization Lab items.

b. There are two inventory point types commonly used within the GIP system.

(1) Primary. Contains all expendable items for an inventory account, which are replenished by placing orders outside of the facility.

(2) Secondary. Points of distribution related to a primary inventory. Expendable items are replenished by determining what is used to order stock from the primary inventory.

c. The GIP system supports the use of multiple control points within one primary inventory. Thus, multiple inventory points may be combined into a larger primary inventory.

d. A VISN or VA medical facility may submit a memorandum to request a waiver from the requirement to use IFCAP GIP or the VHA-approved inventory management system. The request for waiver must contain the specific reason(s) why the current system cannot meet its needs as well as how the proposed system can. The request for waiver must be sent through the VISN Director to the VHA P&LO for approval. An approved waiver does not exempt the facility from meeting national performance metrics.

5. PRIMARY INVENTORIES

a. Primary inventory accounts must be established in accordance with one of the following models described below:

(1) **Inventory with Distribution Points.** A primary inventory with distribution points (secondaries) is a method of tracking supply usage from receipt to consumption. This model maximizes all aspects of the VHA-approved inventory management system, and at a minimum, must be used for supply chain central storeroom inventories.

(2) **Stand-Alone Inventory.** A primary inventory that is also the point of consumption, which does not have distribution points, is typically utilized when specialty expendable items are purchased for one area.

b. There are two categories of inventory "Clinical" and "Non-clinical" that are mandated for full implementation in the VHA-approved inventory management system. These include the following types of inventory:

(1) Dental

(2) Engineering

(3) Environmental

    (4) Imaging

    (5) Laboratory

    (6) Medical Surgical

    (7) Prosthetics

NOTE: At a minimum, one inventory point (if applicable) must be established for each category. Dental, Imaging, Laboratory, and Medical Surgical expendable items may be grouped under a single inventory point within the "Clinical" category.

    c.   Naming Standards in the VHA-approved inventory management system.

    (1) All primary names will be in capital letters.

    (2) Primary names cannot exceed 30 characters.

    (3) Primary names will incorporate the appropriate inventory category: "C" for Clinical and "NC" for Non-clinical. For example, Podiatry could be C-PODIATRY and Electrical Shop could be NC-ELECTRICAL SHOP.

    (4) A ## will be placed in front of the primary name for inventory points that are not part of the two Mandatory Categories reported in performance measures.

NOTE: An inventory category designation of "C" or "NC" shall not be used when naming primary inventory points with a ##.

    (a) The following primaries must use the ## designation:

        1. ##AMMUNITION

        2. ##CONTINGENCY (replaces ##PAN INFLUENZA)

        3. ##INSTRUMENTS (for non-production instruments)

        4. ##OFFICE SUPPLIES

NOTE: No space should be present between the ## and the primary name i.e., ##CONTINGENCY.

    (b) An inventory category designation of ## must also be used when setting up new primary inventory points that will be part of the "C" or "NC" inventory category. The ## designation must be converted to "C" or "NC" within 45 business days of inventory point creation or upon full implementation, whichever is sooner.

    (c) Tracking of Dental and Surgical Stock Instruments.

<u>1</u>. The VA medical facility Logistics department is responsible for supporting the Dental and SPS areas in establishing primary inventory points within a VHA-approved inventory management system for all "stock" dental and surgical instruments. Stock instruments are defined as spare instruments that are not part of sterile peel packs or trays within the current production environment. These instruments shall be added into the inventory management system for appropriate tracking. Once an instrument has been pulled from the "stock" location, it is to be "issued/distributed" from the primary. All drawers/cabinets holding stock instruments must be appropriately barcoded and inventoried.

<u>2</u>. Due to the nature of inventory practices of dental and surgical instruments, inventory points for these items will be exempt from performance measures. All primary inventory points established to support stock dental and surgical instruments shall follow proper naming standards ##INSTR-DENTAL and ##INSTR-SURGICAL.

NOTE: Medical facilities may utilize RTLS to track inventory of Dental and Surgical stock (non-production) instruments instead of tracking them in primary inventory points ##INSTR-DENTAL and ##INSTR-SURGICAL.

d. Items loaded within primary inventory points must have the following mandatory fields completed: Description, Group Category Code, Main Storage Location, Unit of Issue, Unit of Issue Package Multiple, Mandatory Source, Normal Stock Level, Emergency Stock Level, Standard Reorder Point, and Last Cost.

6. EMERGENCY AND DISASTER SITUATIONS

a. The VA Pandemic Influenza Plan (March 2006) permits VA medical facilities to have medical supplies available/stored for future use in the case of a pandemic influenza outbreak, disaster, or emergency.

b. These supplies must be maintained in a primary inventory point designated by the naming standard ##CONTINGENCY or other VHA-approved method such as a third party vendor. Medical supplies must be maintained in accordance with proper inventory procedures (e.g., not contaminated, damaged, expired, or recalled).

(1) A local committee including staff from Infection Control, Safety, Engineering, Nursing, Chief of Staff, and Logistics must review items within the ##CONTINGENCY primary inventory point on an annual basis to ensure that all supplies are available and ready for use. Committee meeting minutes must be maintained for 12 calendar months.

(2) A physical inventory audit of this primary must be conducted annually on a fiscal year basis.

7. SECONDARY INVENTORIES

The secondary inventories are the points of distribution. Secondary inventory point storerooms are maintained at the end user area. Within the VHA-approved inventory

management system, secondary inventories are maintained with normal stock and reorder point levels. They must be actual inventory locations that hold physical inventory and not "ghost" locations. Due to the nature of how secondary inventories function, physical stock on hand rarely matches the inventory management system's on hand quantity at a given point in time. A secondary inventory is replenished from a primary inventory. At a minimum, items within secondary inventory points must be scanned/reconciled at least monthly.

8. CONSIGNMENT INVENTORIES

a. All consignment agreements shall be written and signed by a warranted VA Contracting Officer (CO).

b. The FCLO shall work with the requesting service to determine the cost effectiveness of implementing consignment agreements.

c. The facility shall nominate to the CO a Contracting Officer Representative (COR) for each consignment agreement. If the COR changes, the facility must notify the CO. The COR shall maintain the following documentation at a minimum, either hard copy or electronic, for each consignment agreement:

(1) Copy of the original contract and subsequent modifications for the life of the contract.

(2) Log sheet including all items brought into the facility and those used and wasted in procedures.

(3) Physical inventory documentation (hard copy or electronic) for 24 calendar months.

FUNCTIONAL AREAS REQUIRING INVENTORY MANAGEMENT

CLINICAL "C" CATEGORY
Example: C-DISTRIBUTION or C-DIST

Name	Abbreviation Allowed
AMBULATORY CARE	AMB CARE
ANESTHESIOLOGY	ANES
AUDIOLOGY	AUDIO
BLIND REHABILITATION	BLIND REHAB
BLOOD BANK	BLOOD
CARDIOLOGY	CARDIO
CATHETERIZATION LABORATORY	CATH LAB
CBOC area	CBOC and initials of area i.e. WR, ASP, etc.
CHEMISTRY	CHEM
CYTOLOGY	CYT
COMMUNITY LIVING CENTER	CLC
DAY SURGERY	DAY SURG
DENTAL GENERAL	DEN
DENTAL LABORATORY	DEN LAB
DERMATOLOGY	DERM
DISTRIBUTION	DIST
EAR NOSE THROAT	ENT
ELECTROPHYSIOLOGY LABORATORY	EP LAB
EMERGENCY ROOM	EMER RM
ENDOSCOPY	ENDO
GASTROENTEROLOGY	GI
GERIATRICS	GERI
HEMATOLOGY	HEMAT
HEMODIALYSIS/RENAL	HEMO
HISTOLOGY	HIST
HOME HEALTH	HOME HEAL
HOSPICE	HSP
INFECTIOUS CONTROL	INF CON
INTENSIVE CARE UNIT	ICU
INTERVENTIONAL CARDIOLOGY	INTV CARDIO
INTERVENTIONAL RADIOLOGY	INTV RAD
LABORATORY	LAB
MENTAL HEALTH CLINIC	MENTAL
MICROBIOLOGY	MICRO
NEUROLOGY	NEURO
NUCLEAR MEDICINE	NUC MED
OCCUPATIONAL THERAPY	OT
ONCOLOGY	ONCOL
OPEN HEART	OPEN HEART

Name	Abbreviation Allowed
OPERATING ROOM	OR RM
OPTHALMOLOGY	OPTHO
OPTOMETRY	OPTOM
ORTHOPEDICS	ORTHO
PERFUSION	PERFUS
PHYSICAL MED AND REHAB	PMRS
PHYSICAL THERAPY	PT
PODIATRY	PODIA
PROSTHETICS	PROS
PULMONARY	PULM
RADIATION ONCOLOGY	RAD ONCOL
RADIOLOGY/IMAGING	IMG
RESPIRATORY	RESP
SLEEP LABORATORY	SLEEP LAB
SPEECH THERAPY	SPEECH
SPINAL CORD INJURY	SPIN CORD
SPS PREPARATION	SPS PREP
STERILE PROCESSING SERVICE	SPS
SURGERY	SURG
SUTURE	SUT
TOTAL SUPPLY SUPPORT	TSS
TRANSPLANTS	TRANSPL
UROLOGY	GU
WHEELCHAIRS	WHL CHR
WAREHOUSE	WHSE

NON-CLINICAL "NC" CATEGORY
Example: NC-FACILITIES MANAGEMENT or NC-FM

Name	Abbreviation Allowed
BIOMEDICAL	BIOMED
BOILER PLANT	BOILER
BUILDING MAINTENANCE	BLDG MAINT
CARPENTER SHOP	CARP
ELECTRICAL SHOP	ELEC
ENVIRONMENTAL MANAGEMENT	ENV
FACILITIES MANAGEMENT	FM
GROUNDS	GRNDS
HEATING VENT AND AIR COND	HVAC
JANITORIAL	JANIT
LAUNDRY	LNDRY
LINEN	LIN
LOCK SHOP	LOCK
MAINTENANCE	MAINT

Name	Abbreviation Allowed
MECHANIC SHOP	MECH
PAINT SHOP	PAINT
PLUMBING	PLUMB
SAFETY	SAFETY
TOOL CRIB	TOOL

Non-Performance "##" CATEGORY
Example: ##OFFICE SUPPLIES or ##OFF SUPP

Name	Abbreviation Allowed
AMMUNITION	AMMO
CONTINGENCY	CONTINGENCY
IMPLANTS BIOLOGICAL	IMPL BIO
IMPLANTS NON BIOLOGICAL	IMPL NON BIO
INSTRUMENTS DENTAL	INSTR DEN
INSTRUMENTS SURGICAL	INSTR SURG
NUTRITION SERVICE	NUTR SERV
NUTRITION SUBSISTENCE	NUTR SUBSIST
OFFICE SUPPLIES	OFF SUPP
OFFICE SUPPLIES ADP	OFF SUPP ADP
OFFICE SUPPLIES FORMS	OFF SUPP FORMS
OFFICE SUPPLIES PAPER	OFF SUPP PAPER
PHARMACY	PHARM
POLICE AND SECURITY	POLICE
TEST	TEST
TRAINING	TRAINING

REQUIREMENTS FOR STOCK LEVELS

1. ITEM DEFINITION

    Recurring or Repetitive Items are defined as any expendable item that is stocked for future use in a medical facility, regardless of turnover rate. These items are further broken down into two classifications including Standard and On-demand (in GIP).

    a. Standard items are expendable items that are frequently utilized and that have an established turnover rate.

    b. On-demand (Just In Case) items are those expendable items that must be available at all times and that cannot be ordered on a just-in-time basis without risking a negative impact on patient care or processes. On-demand items will have usage in no more than 4 months in a 12-month period. See Usage Demand Item Report section in Appendix E.

    c. If an On-demand item has usage during more than 4 months within a 12-month period, it **must** be converted to a Standard item.

    d. If a Standard item has usage during less than 5 months within a 12-month period, it **can** be converted to an On-demand item.

2. STOCK LEVELS

    a. Stock levels are established to maintain constant availability of expendable items. Levels for On-demand (Just In Case) items must be kept at a minimum to avoid overstocking and separate requirements are established for managing and monitoring these items. It is important to avoid overstocking and understocking in both the primary and secondary inventories.

    (1) Overstocking increases the risk of damage, outdating, contamination, and obsolescence of inventory items. It also is an inefficient use of financial resources by purchasing and storing more inventory than is required. *NOTE: End of year purchases which cause overstocking of items must be avoided.*

    (2) Understocking creates the risk of unavailability of supplies, which affects the quality of patient care, creates additional purchase costs (overnight shipping), and adversely affects the trust users have in SCM staff.

    (3) At least quarterly, inventory managers and functional area employees shall review inventory points to ensure correct items and levels are maintained.

    b. Types of stock levels in GIP.

    (1) **Normal Stock Level.** The normal stock level represents the largest quantity of an item to be maintained in the inventory point. Normal stock levels **must** be established for all primary and secondary items.

(2) **Emergency Stock Level.** The emergency stock level represents the lowest quantity of an item in the inventory point. The Emergency Stock Report is used to alert staff that an emergency purchase may be required. Emergency stock levels **must** be established for all primary items.

(3) **Temporary Stock Level.** If there is a large variation in demand for an item, such as a seasonal item, a temporary stock level can be entered for a specific period, and it will override set stock levels. This allows the inventory manager to briefly adapt to fluctuations in demand without permanently changing stock levels. Inventory managers are required to enter a delete date when establishing a temporary stock level, so the system automatically deletes that level after the specified date.

(4) **Reorder Point Level.** The reorder point level represents the level at which the item is to be reordered. Reorder point levels **must** be established for all primary and secondary items.

(5) **Optional Reorder Point Level.** The optional reorder point level is used in the auto-generation process to identify items that have fallen below the normal stock level, but have not yet reached the reorder point level. This allows for inclusion of items near their reorder point in upcoming purchases with the same vendor, thereby reducing separate purchases to the same vendor within short periods of time. Setting this level for primary items is recommended.

NOTE: Required levels must not be left blank (null).

3. STOCK LEVEL AUTOMATION

The VHA-approved inventory management system is the main tool utilized in working towards the goal of tracking supplies to the correct cost accounts and functional areas at the lowest level possible. In order for an inventory point to be considered fully implemented, all recurring and repetitive expendable items must be loaded in the IMF and populated in the primary inventory points. All primary inventory points, and when appropriate, secondary inventory points, must be established and populated. Storeroom shelves must be barcoded for all items and neatly arranged. Inventory is replenished through scanning and auto-generation unless point-of-use (POU) equipment is used.

a. **Primary Inventories with Secondary's.** Secondary inventory points shall be scanned as required using the barcode program PRCPH (program name and not acronym) or its successor. Stock will be replenished from the associated primary inventory point. *Example.* When scanning a secondary storeroom using the PRCPH program, if an item's normal stock level on the shelf is 10 and there are 3 remaining, the user will enter 3 into the scanner for what remains on the shelf.

b. **Stand-Alone Primary Inventories.** Primary inventories that serve as both the storage and usage point shall be scanned using the barcode scanner program PRCUS (program name and not acronym) or its successor. Before implementing the PRCUS

scanning method for stand-alone primaries at a facility, staff should be educated on its use. Stand-alone primaries shall not require an annual physical inventory, but must be scanned at least once per month for replenishment or through other electronic means. *Example.* When scanning a stand-alone primary storeroom using the PRCUS program, if an item's normal stock level on the shelf is 10 and there are 3 remaining, the user will enter 7 into the scanner for what is consumed.

   c. **Primary Inventories.** Inventory managers must use the auto-generation option in the VHA-approved inventory management system for creating orders to replenish inventories (if applicable). This process calculates the required quantities necessary to bring stock up to the established normal stock level, reviews preset inventory levels against quantities on hand, and identifies those items below the preset levels, so they may be ordered.

4. BARCODE LABELS

   a. The use of computerized barcode labels is mandatory to identify all expendable items within a primary and secondary inventory point.

   b. Information printed on the barcode label must include the following attributes, at a minimum: IMF, short description, normal stock level, reorder point level, unit of issue, and Inventory Point Identifier (IE). If the levels or unit of issue change, the label must be changed.

Barcode labels need to be affixed at the location where the item is stored, to the fullest extent possible. If it is not reasonably possible to attach a label, a locator list of these labels must be available in the storage location.

REPORTS REVIEW SCHEDULE

1. REQUIREMENTS FOR INVENTORY MAINTENANCE UTILIZING REPORTS

a. Inventory points must be reviewed on a regular basis through the use of inventory management system reports or VHA-approved equivalent. Local procedures for verifying use and review of reports should be established by the FCLO.

b. Documentation showing that reports have been reviewed should be kept for a 12 month period. An exception is made for reports identified with a minimum review frequency of daily and weekly, which will be maintained until the next report is run.

NOTE: For all requirements that specify reports, records or documentation – reports, records or documentation may be paper, scanned and/or maintained electronically (i.e. VHA Office of Supply Chain Data and Informatics Portal Report Tools). Paper and electronically maintained files must be organized and readily accessible.

2. COMPREHENSIVE ITEM REPORT

a. **Description.** This report displays attributes about inventory point items including the national stock number, item master file number, description, group category, levels, last cost, due-in and due-out, and main storage location. This report is often used in conjunction with other reports to obtain more detailed information about items. This report may be used to:

(1) Determine if items are being overstocked by comparing the items quantity on-hand to the normal stock level.

(2) Ensure that items have an appropriate normal stock, reorder point, and emergency level set.

b. **Menu Path.** Primary Inventory Point Menu →Reports Menu → Informational Reports Menu.

c. **Parameters.** All Group Categories.

d. **Minimum Review Frequency.** Semi-Annual.

3. QUANTITY DISTRIBUTION REPORT

a. **Description.** This report displays the quantity and value distributed monthly for each item over the past 12 months and computes an average quantity and value distributed for the 12 month period. Attributes identified in this report include the description, item master file number, unit per issue, reorder point, optional reorder point, temporary stock level, emergency stock level, and normal stock level. This report may be used to:

(1) Review usage trends over a 12 month period which may assist in identifying seasonal items and/or future usage patterns.

(2) Set appropriate stock levels for items based on 12 months of usage history.

(3) Determine estimate of dollars needed to setup a duplicate inventory for a new program.

b. **Menu Path.** Primary Inventory Point Menu → Reports Menu.

c. **Parameters.** Select All Items.

d. **Review Frequency.** Semi-Annual.

4. CONVERSION FACTOR REPORT

a. **Description.** This report displays the group category, national stock number, item master file number, description, quantity on-hand, unit per issue, procurement source, unit per receipt, and conversion factor. This report may be used to identify errors which could affect the receiving process and amount of inventory listed on hand.

b. **Menu Path.** Primary Inventory Point Menu → Reports Menu → Informational Reports Menu.

c. **Parameters.** Select All Group Categories and All Items.

d. **Minimum Review Frequency.** Quarterly.

5. INACTIVE ITEM REPORT

a. **Description.** This report displays items which have not been issued from or received into an inventory point within a specified time period. Attributes identified in this report include the last usage date, last receipt date, due-out quantity, quantity on-hand, total value, and kill when zero (kwz). This report may be used to identify items with no usage during a time period, which may be an indicator that the items are no longer required by an inventory point.

b. **Menu Path.** Primary Inventory Point Menu → Report Menu.

c. **Parameters.** Select All Group Categories, Enter Inactivity Cutoff Month and Year (Accept Default), Standard Items, and Include Zero Quantity Items.

d. **Minimum Review Frequency.** Quarterly.

6. USAGE DEMAND ITEM REPORT

a. **Description.** This report displays the usage/distribution of items between a specified beginning and ending date. Attributes identified in this report include the

national stock number, item master file number, description, unit per issue, last cost, average cost, quantity on-hand, month/year used, quantity used, and total cost. This report may be used to:

(1) Review a 12 month period of On-demand Item (ODI) item usage to determine if items are being used more than 4 months within a 12 month period. Items that are used during a 5th month must be reclassified as a standard item.

(2) Determine which ODI items have no usage within a set time period that may have too much quantity on hand.

(3) Assist with budget forecasting and adjusting stock levels.

b. **Menu Path.** Primary Inventory Point Menu → Report Menu.

c. **Parameters.** 12 Month Date Range, All Items, All Group Categories, On-Demand Items Only, and Sort By Item Number.

d. **Minimum Review Frequency.** Monthly.

7. AVAILABILITY LISTING REPORT

a. **Description.** This report displays the current quantity and value of inventory point items by group category. Attributes identified in this report include the description, national stock number, item master file number, unit per issue, group category, quantity on-hand, due-in, due-out, reorder point, issue multiple, average cost, and total value. Errors in costing are noted by a <=/=> symbol within the "detailed" version of the report, noting quantity on hand times the average cost does not equal the total value of the item. This report may be used to identify obvious errors in quantity on hand, average cost, and total cost.

b. **Menu Path.** Primary Inventory Point Menu → Reports Menu.

c. **Parameters.** Do you want to print a summary only and All Group Categories. Print in detail format to view for costing error's the last week of the month is highly recommended.

d. **Minimum Review Frequency.** Monthly.

8. DAYS OF STOCK ON HAND REPORT

a. **Description.** This report displays items with stock on hand less than or greater than a specified amount of time. Attributes identified in this report include the national stock number, item master file number, description, unit per issue, total usage for the period, average usage per day, quantity on-hand, days of stock remaining, and total selling value of the inventory. This report may be used to:

(1) Determine which standard items have a negative sell value, days left > 9999 (no usage), and days left > category performance requirements.

(2) Determine which standard items have days left < 14 and the % of standard items that have days left < 14.

b. **Menu Path.** Primary Inventory Point Menu → Report Menu.

c. **Parameters.**

(1) 3 Month Date Range, Greater Than 30, All Group Categories, and Standard Items Only.

(2) 3 Month Date Range, Less Than 14, All Group Categories, and Standard Items Only.

NOTE: Report data only good during real-time pull. Cannot replicate data previously pulled for a month and year.

d. **Minimum Review Frequency.** Monthly.

9. HISTORY OF DISTRIBUTION REPORT

a. **Description.** This report displays the distribution history to or from a primary inventory point including distribution to/from, cost center, and total cost. This report may be used to:

(1) Determine reimbursement for stock provided to areas for which funding is not provided.

(2) Trend costs distributed to various program areas in the facility.

(3) Provide documentation to support budget requests.

(4) Monitor distributions for potential change in program expenditure.

b. **Menu Path.** Primary Inventory Report Menu → Report Menu.

c. **Parameters.** To or From Inventory Point, Start Printing Distributions To/From Date, End Printing Distributions To/From Date, and Do you want to break out the cost by Medical Information System (MIS) Costing Section.

d. **Minimum Review Frequency.** Monthly.

10. STOCK STATUS REPORT

a. **Description.** This report displays a summary of primary inventory point performance including the opening balance, receipts, usage, adjustments, closing

balance, turnover rate, inactive supply, and long supply for standard, on-demand, and all items. This report may be used to:

(1) Ensure that the standard item turnover rate, inactive supply percent, and long supply percent is compliant for the metric category.

(2) Determine if questions should be asked regarding the number of positive or negative adjustments, ensure the closing balance is not negative.

(3) Determine if ODI usage seems excessive.

b. **Menu Path.** Primary Inventory Point Menu → Report Menu.

c. **Parameters.** Select all default parameters.

NOTE: Data is only accurate during current month and year (real-time) pull.

d. **Minimum Review Frequency.** Twice-Monthly (every 2 weeks).

11. DUE-IN REPORT

a. **Description.** This report displays inventory point items which have outstanding due-ins including the outstanding transaction number, associated purchase order, vendor, estimated delivery date or partial numbers not received in, and the due-in quantity. This report may be used to determine which items have due-ins that have been open for an extended period of time and if there is an excessive number of due-ins that have not been completed.

b. **Menu Path.** Primary Inventory Point Menu → Receiving and Distribution Menu.

c. **Parameters.** All Group Categories.

d. **Minimum Review Frequency.** Weekly.

12. EMERGENCY STOCK REPORT

a. **Description.** This report displays inventory point item quantities that are at or below the emergency level (assuming an emergency level has been set) regardless or not if the items have been ordered. Attributes identified in this report include the national stock number, item master file number, description, unit per issue, normal level, emergency level, quantity on-hand, quantity due-in, and quantity due-out. This report may be used to determine which items have an on-hand quantity at or below the emergency level and which items have no quantity on hand.

NOTE: Items with an emergency stock level set to blank/null will not be listed on this report.

b. **Menu Path.** Primary Inventory Point Menu → Report Menu.

   c. **Parameters.** All Group Categories.

   d. **Minimum Review Frequency.** Weekly.

13. PACKAGING PROCUREMENT DISCREPANCY REPORT

   a. **Description.** This report displays inventory point item discrepancies related to packaging, conversion factor, and vendor errors. Attributes identified in this report include the national stock number, item master file number, description, vendor, unit per issue, unit per purchase, and unit per receipt. Items will not be able to be received into a primary if there is a packaging or conversion factor error. This report may be used to look for unit per issue, unit per purchase, unit per receipt, and mandatory source errors.

   b. **Menu Path.** Primary Inventory Point Menu → Receiving and Distribution Menu.

   c. **Parameters.** Select All Items.

   d. **Minimum Review Frequency.** Weekly.

14. LIST DISTRIBUTION ORDERS TO/FROM INVENTORY POINT

   a. **Description.** This report displays the distribution orders which have not been posted from a primary to a secondary inventory point and includes the order number, date, type, status, and delivered to inventory point. This report may be used to:

   (1) Print picking tickets from the primary for all orders which have been released, but have not had a picking ticket previously printed.

   (2) Verify that picking tickets have been posted before scanning the secondary again.

   b. **Menu Path.** Primary Inventory Point Menu → Receiving and Distribution Menu.

   c. **Parameters.** Do you want to release orders now, Do you want to print picking tickets for released orders, and Do you want to breakout a list of items on each order.

   d. **Minimum Review Frequency.** Daily.

15. ABBREVIATED ITEM REPORT

   a. **Description.** This report displays one line per item including the description, national stock number, item master file number, quantity on hand, unit per issue, main storage location, and additional storage locations. This report may be used to:

   (1) Determine an appropriate group category for an item being added to an inventory point.

   (2) Identify main and additional storage locations for an item.

   b. **Menu Path.** Primary Inventory Point Menu → Reports Menu → Informational Reports Menu.

   c. **Parameters.** Select All Group Categories and All Items

Minimum Review Frequency. As needed.

**REQUIREMENTS FOR EXPENDABLE SUPPLY INVENTORY ACCURACY AND
INVENTORY PERFORMANCE MANAGEMENT**

This section focuses on the requirements for ABC inventory classification and conducting a physical inventory count audit of primary inventory points.

a. **ABC Inventory Classification.**

(1) In order to increase inventory accountability by establishing more rigorous requirements for higher-dollar usage value items than lower-dollar usage value items, the VHA has adopted ABC classification principles for inventory management. As such, all primary inventory points, except stand-alone primaries, must utilize the ABC inventory classification method for all items. The ABC classification method uses the Pareto principle and is based upon the Annual Usage Dollars of all items within a specific inventory point, which are ranked from highest to lowest (see Table 1. ABC Classification Example). The formula for calculating the Annual Usage Dollars of an item is the Annual Usage Quantity multiplied by the Average Unit Price. Inventory point items with the highest 80 percent of Annual Usage Dollars shall be classified as "A." Items with the next highest 10 percent of Annual Usage Dollars shall be classified as "B." Lastly, items representing the remaining 10 percent of Annual Usage Dollars shall be classified as "C." ABC classification shall be specific to each inventory point. For example, an item within inventory point "x" could be classified as an "A" item, while the same item within inventory point "y" could be classified as a "B" item. The P&LO has developed a tool that creates a spreadsheet per primary inventory point to identify the ABC classification of items. Medical facilities using the Generic Inventory Package (GIP) to manage inventory points must utilize this tool to identify expendable supply items as A, B, or C. For medical facilities using inventory management software other than GIP to manage inventory points, it must ensure that the method for determining A, B, and C matches the requirements stated in this policy.

(2) All new items added to a primary inventory point during a fiscal year, must be classified as "C" items until the next year.

(3) Each item must have an A, B, or C designation placed on a dot label next to the bar code label.

(4) All inventory points must be reclassified at the beginning of a new fiscal year (no later than October 31). It is possible for the classification of an item to change from one year to the next. The ABC inventory classification spreadsheet for each primary must be archived (hardcopy or electronic) for 24 months.

Table 1. ABC Classification Example

Master Item	Annual Usage Qty.	Average Unit Price $	Annual Usage $	Annual Usage $ %	Annual Usage $ Cum. %	Class
2154	200	90.00	18,000.00	38.69	38.69	A
3763	400	25.75	10,300.00	22.14	60.83	A
5675	175	52.00	9,100.00	19.56	80.39	B
5943	45	55.00	2,475.00	5.32	85.71	B
3333	89	20.00	1,780.00	3.83	89.54	B
5478	60	28.45	1,707.00	3.67	93.21	C
9735	45	35.25	1,586.25	3.41	96.61	C
2100	35	45.00	1,575.00	3.39	100.00	C
	Total		$46,523.25			

b. **Conducting a Physical Inventory Count Audit of Primary Inventory Points With Secondaries.**

(1) The physical inventory frequency for items within a primary inventory point shall be based upon the assigned ABC classification. At a minimum, primary inventory point items must be physically counted as follows:

(a) "A" classified items - October, January, April, and July

(b) "B" classified items - March and September

(c) "C" classified items - September

(2) Steps to conducting a physical inventory count audit:

(a) Verify that items are placed in their proper location(s) prior to conducting the physical count.

(b) Ensure all issues, receipts, due-ins, and due-outs are processed prior to conducting the audit. Items on the dock and not yet received, do not need to be counted. A report (i.e. Abbreviated Item, Physical Count Form with On Hand Quantity, etc.) must be run prior to conducting the physical inventory count audit so that the on hand quantity found within the VHA approved inventory management system can be captured.

(c) Establish two teams, each consisting of one counter and one recorder. These individuals shall be trained on performing an accurate physical inventory count audit and capturing results in the proper format prior to conducting the audit.

(d) Conduct physical inventory count audit of all A, B, or C items within the inventory point. Use a document with current physical count form attributes and values sorted by

the master item main storage location to record the physical inventory count. Identify discrepancies between team physical count forms and/or the VHA approved inventory system generated on hand quantities. If discrepancies exist, they must be reviewed for cause and possible action.

(e) Use a scanner and the PRCPH menu option (or current menu option to denote a physical count transaction) to make corrections, if necessary, within the inventory system before the close of business the same day the physical inventory was completed.

(f) A successful physical inventory count audit of a primary inventory point shall have an accuracy rate of at least 95 percent for "A" items, 93 percent for "B" items, and 90 percent for "C" items.

$$\text{Inventory Accuracy Percentage} = \left[1 - \left(\frac{\text{the sum of the absolute variance in physical inventory quantity}}{\text{the sum of the total on hand quantity}}\right)\right] \times 100$$

If the accuracy rate is below the acceptable percentage for the assigned ABC classification, an action plan must be created to ensure inventory accuracy is achieved and maintained at the acceptable percentage. The action plan must be approved by the VISN CLO within one month of the physical inventory completion date. Upon VISN CLO approval, physical inventories of the unacceptable category will occur on a monthly basis until an acceptable accuracy rate is achieved, and the regular physical inventory frequency for the assigned ABC classification applies again.

(3) Physical inventory count documentation must be maintained by the logistics program at the medical facility for each primary with secondaries for a minimum of 24 calendar months as detailed below.

(a) A memorandum signed by the FCLO that lists the accuracy rate, identifies all discrepancies, and details the corrective action plan as well as any steps already taken to resolve the discrepancies. A copy of this document shall also be sent from the FCLO to the VISN CLO.

(b) Any data printouts used to determine on hand quantities during the physical inventory count audit.

(c) Physical inventory count audit worksheets (i.e. physical count form) with discrepancy annotations and annotations from discrepancy recounts. These worksheets shall include the signature of each physical inventory team member on the last page of each set of worksheets.

(d) A copy of the GIP - Adjustment Voucher Recap Report showing adjustments made.

c. **Stand-Alone Primaries.** No physical inventory count audit is required as long as an inventory is taken by scanner or other electronic means at least once per month.

d. **Ammunition.**

(1) At a minimum, a physical inventory count audit of ammunition will be conducted on a semi-annual basis. These audits will be conducted by the organization authorized to carry firearms and the facility Accountable Official (AO) or designee. If the physical count of ammunition does not match the on hand quantity found in the VHA-approved inventory management system, a quarterly physical inventory count audit will be required by that facility for the remainder of the fiscal year.

(2) Data resulting from all internal inventories of ammunitions conducted by VA organizations that are authorized to carry such items will be provided to the AO or designee upon request.

(3) Medical Center Director will certify that ammunition inventories are included in the Annual Certification of Property Inventories or applicable report as a separate line item.

e. **Requirements for Report of Surveys.**

(1) Primaries with secondaries and stand-alone primaries – A Report of Survey must be initiated for aggregated discrepancies ≥ $5,000 upon discovery during a physical inventory count audit or at any other time an adjustment of ≥ $5,000 is required.

(2) Ammunition – A Report of Survey must be initiated when there is a discrepancy between the physical inventory count and the VHA-approved inventory management system generated on hand quantity.

CLEAN/STERILE INVENTORY POINT STOREROOMS

All clean/sterile inventory points, are designed to promote cleanliness, visibility, safety, and efficiency of distribution. The inventory of these areas needs to be verified on a monthly basis for accuracy of inventory balances, expired/outdated items, damaged, or obsolete items. The rotation of stock is vital to prevent unnecessary outdates and additional costs.

1. TEMPERATURE AND HUMIDITY

a. Logistics expendable supply storage locations must have a stable environment without extreme changes in temperature and humidity. Items stored within these locations must comply with temperature and humidity requirements in accordance with manufacturer specifications. Heating, Ventilation, and Air Conditioning (HVAC) units that supply ventilation air to Logistics expendable supply storage locations are permitted to operate as originally designed, meeting codes and standards at the time of design/construction. Medical facilities may utilize RTLS temperature and humidity tracking to produce alerts and historical monitoring reports.

NOTE: Expendable supply storage locations outside Central Supply are provided with ventilation air supplied from surrounding areas and are subject to the operating constraints of the system providing ventilation air to the general area.

b. Logistics expendable supply storage locations must meet the following ventilation parameters:

Location	Airflow	Relative Humidity (%)	Temperature (F)
Clean supply room	Positive (out)	< 75	64 - 78
Breakout room	Positive (out)	< 75	64 - 78
Bulk storage/warehouse	Not required	< 75	64 - 78

NOTE: Recommendations are based on information from the International Association of Healthcare Central Service Material Management (IAHCSMM).

c. When ventilation parameter readings for Logistics expendable supply storage locations are out of compliance, Logistics will do the following:

(1) Notify Sterile Processing Service (SPS) for their guidance and corrective action when reprocessed items are present.

(2) Notify using service if patient safety is at risk.

(3) Review manufacturer packaged item specifications to ensure continued safe use of items and remove those items determined no longer safe for use.

(4) Contact the manufacturer for specific guidance on their items if further clarification is required.

NOTE: This guidance does not apply to items in transit.

(5) Contact responsible HVAC service to correct any ongoing issues and document correspondence.

d. Temperature and humidity must be monitored on a daily basis, by local facility protocol (i.e. Logistics or Facilities Management staff), and records retained, hard copy or electronic, for 12 calendar months.

2. STORAGE

a. Access to clean/sterile storerooms shall be restricted to authorized personnel, by the FCLO. Other persons with official business, and when accompanied by an appropriate supervisor or designee, will be authorized entrance to storage areas. *NOTE: The facilities comprehensive risk assessment shall be consulted to determine if needles and syringes require additional access control.*

b. The lowest shelves in storage areas shall be solid and must have at least 8 inches of space between the floor and bottom shelf. This space will allow access for cleaning to avoid contamination. Top shelves and contents shall be arranged at least 5 inches from the ceiling and at least 18 inches from sprinkler heads. Items must be at least 2 inches from exterior building walls to avoid condensation and contamination. *NOTE: For further guidance on fire codes and standards refer to http://www.nfpa.org.*

c. Shelves, bins, and items must be checked, with necessary corrective action taken, on a weekly basis for cleanliness, expiration/outdates, and damage. This check will be documented on a weekly sign-off sheet posted in the room including initials of person who performed check and date completed.

(1) One log sheet may be maintained for the entire room or by supply section/row. If a particular room contains multiple inventory points, log sheets shall be maintained for each inventory.

(2) Log sheet documentation will be maintained at the facility for 12 calendar months.

d. Storerooms must be kept clean and uncluttered (i.e., no visible dust on products or in bins, no visible soiling, etc.).

e. Shelving must be kept dry.

f.   Shelving must be nonabsorbent, non-corrodible, easily cleanable, and shall meet all applicable National Standards Foundation (NSF)/American National Standards Institute (ANSI) standards. Bare wood shelves are prohibited.

g.   Supplies must never be stored directly on the floor.

h.   Supplies must not be stored where they could become wet or compromised.

(1) Items stored near sinks and ice machines shall be protected utilizing a formal barrier (i.e. plexi-glass) or a fully enclosed cabinet.

(2) New storerooms for expendable supplies shall be constructed without sinks and ice machines.

i.   Supplies shall not be stored directly on window sills. If a storeroom has a window, the window must be covered with an ultraviolet barrier.

3. INFECTION CONTROL

All employees must help ensure that all expendable items are handled under the best possible conditions for maximum safety and protection of patients, employees, and visitors. The following guidelines must be observed:

a. No tobacco products, food, drinks, or patient dietary items shall be consumed or stored in any medical supply storage area or where the dispatching of patient care supplies or equipment is performed. Such items may encourage microorganism growth and endanger valuable medical supplies.

b. Portable fans shall not be used in clean/sterile storerooms.

c. Corrugated Containers. Outside shipping and corrugated containers must not be used for storage of items in clean/sterile storerooms.

d. To maintain and control a clean environment in clean/sterile storerooms, there must be no exposed pipes or ducts to collect lint and dust. Light fixtures should be recessed.

e. In cooperation with EMS, a daily cleaning schedule for clean/sterile storerooms will be developed, implemented, and enforced. Sweeping is prohibited in clean/sterile storerooms.

f. A schedule shall be established with the service that manages pest control to review and ensure storerooms remain free of insects, rodents, and other vermin. Reports of pest infestation will be investigated with appropriate action taken.

4. TRANSPORTATION OF CLEAN/STERILE EXPENDABLE ITEMS TO ANOTHER BUILDING AND/OR FACILITY

VAMC personnel are allowed to transport individual items (those already removed from outside shipping containers and stored in a clean room) as well as bulk items to another building and/or facility as needed. The requirements below for the item and transportation vehicle must be followed when transporting items to another building and/or facility:

a. **Items.**

(1) Manufacturer's instructions must be followed with regard to handling, temperature and humidity recommendations.

(2) Before items are placed in the new clean storage area, the clean items will be inspected for event related sterility. Items with any damage to packaging, crushing or punctures or evidence of moisture will be removed and appropriately discarded.

(3) Clean items will never be transported in the same containers with contaminated items.

(4) Sealed plastic containers or plastic bags shall be used for transporting items.

(5) Plastic containers must be cleaned prior to using them to transport individual items.

(6) External shipping cartons (i.e. corrugated boxes) will be considered contaminated and will not come in contact with individual clean/sterile items.

b. **Transportation Vehicles.**

(1) Prior to transportation of items, the vehicles will be inspected to identify any issues which may affect the sterility of items during transport.

(2) Vehicles used for transportation of clean/sterile items will be fully enclosed to prevent outside contamination.

(3) Vehicles shall not be left unlocked or unattended during transportation of clean/sterile items from one facility to another. If the vehicle must be unattended, it must be locked/secure.

(4) The vehicle must contain mechanisms/devices which allow for transport containers to be secured during transport to avoid shifting, preventing damage or contamination.

(5) When transporting clean/sterile items from one building to another and a motor vehicle is not necessary, items will be transported in sealed plastics containers or plastic bags (as indicated above) and placed in an enclosed or covered cart.

5. REQUIREMENTS FOR WORK ATTIRE

a. Logistics staff must adhere to local medical facility policy established for work attire requirements. Work attire policy written by logistics at the medical facility level must be reviewed and approved by the local infection control group prior to implementation.

b. The proper use of work attire and Personal Protective Equipment (PPE) is an essential environmental control which promotes both patient and staff health.

REQUIREMENTS FOR ENGINEERING AND ENVIRONMENTAL INVENTORY POINT STOREROOMS

The Engineering and Environmental inventory points products (non-clinical) must be stored in a manner that promotes item integrity and protects them against pilferage.

a. Shelves and their contents must be at least 5 inches from the ceiling and at least 18 inches from sprinkler heads. ***NOTE:*** *For further guidance on fire codes and standards refer to* http://www.nfpa.org*.*

b. Items shall not be stored directly on the floor.

c. Shelves, bins, and items must be checked on a monthly basis for cleanliness, expiration/outdates, and damage. This check must be documented on a monthly sign-off sheet posted in the room including initials of person who performed check and date completed.

(1) One log sheet may be maintained for the entire room or by supply section/row. If a particular room contains multiple inventory points, log sheets must be maintained for each inventory.

(2) Log sheet documentation must be maintained at the VA medical facility for 12 calendar months.

d. Storerooms must be kept free of clutter.

e. A schedule must be established with the service that manages pest control to review and ensure storerooms remain free of insects, rodents, and other vermin. Reports of pest infestation will be investigated with appropriate action taken.

f. Access to storerooms.

(1) Access to storerooms shall be restricted to Engineering and Environmental authorized personnel. Other persons with official business, and when accompanied by an appropriate supervisor or designee, will be authorized entrance to storage areas.

(2) If the storeroom is not staffed 24 hours a day, 7 days a week, a security access card, code, or key will be provided to access the storeroom. A detailed procedure shall be posted with a log sheet or other process to instruct staff how to sign out expendable items when inventory management staff is not present. The process will be monitored weekly and will include the following:

(a) IMF number or item identifier

(b) Item description

(c) Quantity

(d) Item destination

(e) Personnel obtaining item including phone extension

(f) Time and date the item was removed from storeroom

(g) Any other pertinent information

REQUIREMENTS FOR PHARMACY

Pharmacy Service at all VA medical facilities shall adopt the following inventory management practices.

a. **Background.** Pharmaceuticals are primarily purchased through a Pharmaceutical Prime Vendor utilizing a proprietary ordering system. The current Pharmaceutical Prime Vendor's proprietary ordering system contains an inventory management software program. The program provides a wealth of information to assist facilities in minimizing the total replenishment cost of inventory. The goal of effective inventory management is to minimize the total replenishment cost, which includes both carrying cost and order line cost. The Reorder Quantity (ROQ) is the quantity of stock to order that minimizes all costs. The prime vendor inventory management software calculates the ROQ for each item ordered. Other available inventory management tools that are utilized with the prime vendor's inventory management program for VHA pharmaceutical inventories include:

(1) **Demand Forecasting.** This means weighting factors are applied to past purchases to help factor trends into the calculations of Reorder Point (ROP) and ROQ for more accurate inventory management.

(2) **Calculations of Reorder Point (minimum safety stock level) and Reorder Quantity.** Generation of barcoded shelf labels containing this information can be used to trigger the order process.

(3) **Ability to Override Normal.** Ability to override normal demand forecasting when necessary for an item that does not fit the mold of the velocity grouping (essentially increasing safety stock or "lead" levels or desired ordering levels while still letting the system continue to trend with purchase history on those items).

(4) **Ability to Designate Lead-time.** Ability to designate lead-time, which affects required inventory stock levels.

(5) **Calculation of Inventory Turns.** Calculation of inventory turns. *NOTE: This refers to the number of times an item turns over within an inventory in a designated period of time from replenishment to consumption.*

(6) **Support of the ABC Inventory Analysis Method.**

(a) Approximately 70 percent of inventory dollars are spent on 10 percent of the products. These are "A" items and need to be monitored closely to reduce total inventory carrying cost.

(b) Approximately 20 percent of the inventory dollars are spent on 20 percent of the products. These are "B" items and can be managed less aggressively.

(c) The "C" items are 10 percent of the inventory dollars and 70 percent of the products. These items can be managed least aggressively and the ordering process for these items can be streamlined to reduce daily workload requirements for these items.

(7) **Report Capabilities.** Report capabilities need to be available to support the available tools.

b. **Program Implementation.**

(1) The Prime Vendor Inventory module must be used to manage all VA medical facility Pharmacy inventories.

(2) The ROQ is calculated for each line item using the inventory management software. In order to determine the proper ROQ, the prime vendor asset management system must be enabled and parameters set accordingly. The supply months are to be set at 4-months usage based on dollars. The optional "include current month" setting is encouraged for use to help keep the values reflective of moving purchasing trends; and 7 days is considered an appropriate number of days to include in that setting.

(3) Barcode shelf labels containing the product name, item number, ROP, and ROQ must be affixed to all stock locations.

(4) Barcode shelf labels must be updated quarterly for "A" items and annually for "B" and "C" items, or as dictated by changing product movement. This is best done by printing only items where the ROP has changed.

(5) The hand held barcode reader provided by the Prime Vendor is used for scanning the shelf label for items whose schedule dictates reorder, entering the quantity of product desired (or a zero quantity to let the system introduce the quantity automatically), and uploading the order into the Prime Vendor computer system for transmission. If quantities are manually entered at time of scan, the Purchase Order (PO) process within the Prime Vendor system can still be used to compare those quantities against those suggested by the system. The orders can then be transmitted to the Prime Vendor.

(6) Sites may also use an automated inventory management and replenishment system to generate an order for the Prime Vendor.

(7) The ABC method of inventory management is used to determine inventory reordering frequency, as follows:

(a) "A" items must be inventoried and ordered a minimum of two times weekly. With velocity days' supply (ROQ) set at 7 days and shelf-label days' supply ROP set at 3 days.

(b) "B" items are to be inventoried and ordered a minimum of weekly. With velocity days' supply set at 10 days and shelf-label day's supply set at 5 days.

(c) "C" items are to be inventoried and ordered once every 14 days. With velocity days' supply set at 14 days and shelf-label days' supply set at 7 days.

NOTE: Procurement staff must balance the utilization pattern of the facility with the knowledge of certain aspects of medical care to determine the appropriate quantity level to order. This judgment must factor into ordering: knowledge of recent pharmaceutical and supply recalls, manufacturer back orders, CMOP prescription returns to the facility, seasonal variation in demand, targeted drug conversion initiatives, limited quantity ordering restrictions, changing formulary and contract status, unusual patient cases or clinic demand that require a higher than average product requirement, and the space availability to store the product for a 2 week period. These factors may override the frequency or quantity requirements, to minimize unnecessary purchasing or risk inadequate storage space.

(8) Validation of the order quantity can be systematically activated. This is done by activating the PO Prepare preferences.

(a) Under Administration → User → PO - Prepare on the menu, the user should check the "Validate Over/Under Quantity" field. The quantity is suggested to be set at 25 percent, though that can be adjusted to suit customer needs.

(b) The user needs to select Contract Item and Best Price to optimize order review opportunities. This over and under validation checks the quantity in orders against the system suggestion during the PO Prepare process and tag those items whose order quantity is out of line with expectations.

(9) End of year purchases make pharmaceutical inventories increasingly difficult to manage and are to be avoided.

c. **Monitoring.** Inventory turnover is the primary measure of the effectiveness of inventory management. Increasing inventory turns decreases inventory carrying cost, but may increase order line cost.

NOTE: The appropriate balance must be struck to keep total replenishment cost low.

(1) The theoretical turns report is run monthly for each inventory category A, B, and C, as well as the report for all classes combined.

(2) The forecast exceptions report is used monthly to adjust minimum and maximum inventory levels and order points to recommended levels.

d. **Reporting.**

(1) The Pharmacy Benefits Management (PBM) on a quarterly basis shall obtain from the Prime Vendor a copy of the 12-Month Turns Forecast Report Summary. This report shall be aggregated by PBM and shared with the VISN Pharmacist Executives (VPE) and the National Director of Logistics Operations, P&LO (10NA2) on a quarterly basis.

(2) An annual wall-to-wall inventory of all items must be completed by individual facilities by February 28th of each calendar year and posted to the National Pharmacy Inventory SharePoint (NPIS) site or current database by April 1. Each facility should retain the annual inventory records for 3 years. The PBM aggregates the reports nationally, returns a report to the VPEs, and forwards a copy to the VHA P&LO (10NA2) Chief of Policy and Assessment for monitoring purposes. ***NOTE:*** *Minimum standards for conducting the annual inventory are determined by PBM.*

　　e. **Consolidated Mail Outpatient Pharmacy.**

　　(1) CMOPs, like Pharmacy, use a prime vendor to supply the vast majority of products that are carried in inventory. CMOPs are large automated-dispensing locations that utilize third-party inventory management software to predict product demand and to provide information for electronic Prime Vendor ordering and inventory management information.

　　(2) Inventory days of stock on hand for CMOP locations must generally be ≤ 10 for those products that can be procured through the Pharmacy prime vendor. CMOP will report inventory turns and the percent of prescriptions cancelled back to the Medical Center Pharmacies to the PBM quarterly. ***NOTE:*** *CMOP Logistics staff must balance the utilization patterns of the VA Medical Centers with the knowledge of certain aspects of product availability in the supply chain to determine the appropriate quantity level to order. This judgment must factor into ordering: number of prescriptions canceled back to Medical Center Pharmacies due to CMOP out of stock situations, knowledge of recent pharmaceutical and supply recalls, manufacturer back orders, potential upcoming pharmaceutical shortages, seasonal variation in demand, targeted drug conversion initiatives, changing formulary and contract status and known price changes. These factors may override the frequency or quantity requirements, to minimize unnecessary purchasing or risk inadequate storage space.*

　　(3) CMOPs must conduct yearly wall-to-wall inventories and report the inventory results to PBM.

　　f. **Pharmacy Drug Supply Chain Security Act.**

　　(1) The VA medical facility Pharmacy manager is responsible for compliance with the Drug Quality and Security Act (DQSA) and Title II of this law entitled Drug Supply Chain Security Act (DSCSA), which outlines critical steps to build an electronic interoperable system to identify and trace certain prescription drugs as they are distributed in the United States by November 27, 2023. For dispensers, requirements for tracing of products through the pharmaceutical distribution supply chain went into effect on July 01, 2015. However, the Food and Drug Administration (FDA) does not intend to take action against dispensers who, prior to November 01, 2015, accept ownership of product without receiving the product tracing information.

　　(a) Dispensers must report illegitimate product to the FDA within 24 hours of making this determination.

(b) Dispensers must also produce 3T information upon request by the FDA or other regulatory agency within 2 business days of that request in accordance with section 582 of the Food, Drug, and Cosmetic Act. For more information on the DSCSA, see FDA guidance at:
http://www.fda.gov/Drugs/DrugSafety/DrugIntegrityandSupplyChainSecurity/DrugSupplyChainSecurityAct/ucm424963.htm

(2) Definitions.

(a) <u>Authorized.</u> In the case of a manufacturer or repackager, having a valid registration in accordance with section 510; in the case of wholesale distributor, having a valid license under state law or section 503(e); in the case of a third-party logistics provider (TPL), having a valid license under state law or section 584(a) (1); and in the case of a dispenser, having a valid license under state law.

(b) <u>Dispenser.</u> A pharmacy or clinic that issues medication to a patient for personal use.

(c) <u>Prescription Drug.</u> A drug for human use subject to section 503(b)(1). Exceptions under the DSCSA include:

<u>1.</u> Over the counter medications

<u>2.</u> Medication borrowed to meet a specific patient's needs

<u>3.</u> Medication transferred between sites under common control

<u>4.</u> Public health emergencies

<u>5.</u> Distribution of minimal quantities of product by a licensed pharmacy to a licensed practitioner for office use.

<u>6.</u> IV product or fluid or caloric replenishment

<u>7.</u> Dialysis products, irrigation solutions, and sterile water

<u>8.</u> Medical gas

<u>9.</u> Medication contained in commercially prepared kits

<u>10.</u> Compounds made in compliance with Food, Drug, and Cosmetic Act section 503A or 503B.

(d) <u>Product.</u> A prescription drug in a finished dosage form for administration to a patient without substantial further manufacturing (such as capsules, tablets, and lyophilized products before reconstitution). See DSCSA Guideline Document, Appendix B, dated November 18, 2015, for list of exceptions.

(e) <u>Trading Partner.</u> A manufacturer, repackager, wholesale distributor, or dispenser from whom a manufacturer, repackager, wholesale distributor, or dispenser accepts direct ownership of a product from one of these entities; TPL provider from whom the manufacturer, repackager, wholesale distributor, or dispenser accepts direct possession of a product or to whom a manufacturer, repackager, wholesale distributor, or dispenser transfers direct possession of a product.

(f) <u>3T Data.</u> Refers to the Transaction History, Transaction Information, and Transaction Statement as defined in the DSCSA.

(g) <u>Transaction History (TH).</u> A statement, in paper or electronic form, including the transaction information for each prior transaction going back to the manufacturer of the product.

(h) <u>Transaction Information (TI).</u> The components required to be present on the transaction statement include:

    <u>1.</u> Proprietary or established name(s) of the product

    <u>2.</u> Strength and dosage form of the product

    <u>3.</u> National Drug Code number of the product

    <u>4.</u> Container size

    <u>5.</u> Number of containers

    <u>6.</u> Lot number of the product (not necessary if shipped directly from the manufacturer to the vendor transferring it to the pharmacy)

    <u>7.</u> Date of transaction

    <u>8.</u> Date of shipment (if more than 24 hours after date of the transaction)

    <u>9.</u> Business name and address of the trading partner <u>from</u> whom ownership is being transferred

    <u>10.</u> Business name and address of the trading partner <u>to</u> whom ownership is being transferred

(i) <u>Transaction Statement (TS).</u> A statement, in paper or electronic form that the entity transferring ownership of a product in a transaction provides to the entity receiving ownership of the product. It contains the following information:

    <u>1.</u> A statement that the transferring entity is authorized as required under the DSCSA

    <u>2.</u> Received the product from an entity that is also authorized under the DSCSA

3. Received 3T information from the prior owner of the product (if applicable) as required under section 582 of the DSCSA

4. Did not knowingly ship a suspect or illegitimate product

5. Had systems and processes in place to comply with the verification requirements under section 582 of the DSCSA

6. Did not knowingly provide false transaction information

7. Did not knowingly alter any previous 3T information

(j) Non-Pharmaceutical Prime Vendor (non-PPV) Purchase. Any prescription drug transaction that requires 3T data exchange that was not purchased through the VA's current pharmaceutical prime vendor or a drop shipment or specialty distribution drug purchased through the pharmaceutical prime vendor.

(3) Guidance.

(a) Chief, Pharmacy Service or Designee and Director, CMOP or Designee

1. Ensure there is a SOP that complies with the medical facility's record management policy to maintain 3T records for prescription drug purchases for a minimum of six (6) years by November 01, 2015.

a. Pharmaceutical Prime Vendor (PPV) purchases: To access the 3T available on the VA's PPV electronic ordering system, please refer to DSCSA Guideline Document, Appendix A, dated November 18, 2015.

b. Non-Pharmaceutical Prime Vendor (non-PPV) purchases: Ensures a process is in place (paper or electronic) to capture and maintain the 3T data for all non-PPV purchases. Paper versions of the 3T data may also be scanned into an electronic file.

2. Ensure the SOP defines:

a. When VA Pharmacy personnel downloads the PPV 3T data

b. How often the Chief of Pharmacy will receive a report that all 3T data has been filed

c. How VA Pharmacy ensures prescription drug purchases are only from authorized trading partners

d. How the 3T data will be retrieved from storage in response to a regulatory agency request or drug recall

e. Procedure for borrowing prescription drugs. Product borrowed to meet a specific patient's need is exempt from the requirements of the DSCSA. The pharmacy

shall only borrow from Authorized Trading Partners as defined under section 581 (2) (D) of the DSCSA.

f. Procedures for products shipped to the VA facility without appropriate documentation. Prescription drugs shipped to the facility without documentation that meet 3T requirements, the VA pharmacy staff member should not receive the shipment. If the shipment was received by non-VA pharmacy staff, then the prescription drug(s) should be quarantined separate from the prescription drug inventory until the vendor provides the appropriate 3T documentation. If the trading partner does not provide appropriate 3T documentation, the VA pharmacy should follow procedures to return the prescription drug to the trading partner.

g. Procedures for investigating suspect prescription drug product. The procedures should include a process to quarantine the suspect product from the pharmacy's inventory, reviewing the 3T documentation, and conducting an investigation with the trading partner. If the investigation determines that the prescription drug is illegitimate, the pharmacy will file FDA form 3911 to report the incident within 24 hours of making the determination.

h. Transfer of product from one VA facility to another does not require the transfer of 3T data since it is within the same organization. See DSCSA Guideline Document, Appendix B, dated November 18, 2015, for list of exceptions.

REQUIREMENTS FOR DISTRIBUTION FROM A CENTRAL STOREROOM

1. Handle and store items so that they do not become crushed, bent, compressed, or punctured.

2. Bundling of clean/sterile packaged items shall never be done by using rubber bands, paper clips, tape, or any means which may cause damage to the packaging.

3. Items that fall on the floor must be inspected for damage to determine if there is a need for reprocessing or disposal. If the item or packaging is wet, soiled, punctured, ripped or torn, there is a risk that the item's sterility is compromised, and must be removed from storage.

4. Markings made on manufacturer clean/sterile packages using any type of pen (ballpoint, felt, rollerball, etc.) or pencil shall be limited to external manufacturer label areas and shall not cover any manufacturer writing.

5. Distribution carts must be cleaned and disinfected as needed.

6. Clean and soiled supplies must never be transported together. If a cart is used to transport a soiled item, it must be properly cleaned before being used for any other supplies.

7. Stock must be rotated using the first-in, first-out (FIFO) method, which is the practice of rotating stock to ensure that older supplies are used before newer items. Supplies on the shelf may be pulled first from the top right, front and new supplies may be stocked beginning on the left, back, and bottom. Other processes designed to support FIFO are also acceptable. For items with expiration dates, stock must be rotated using first-expired, first-out (FEFO). When no expiration date is present on the package, the manufacturer will be contacted to determine an appropriate shelf life and documentation of this determination will be maintained for audit purposes.

8. Clean/sterile packaged items sent to other areas must be transported in closed carts, exchange carts, covered carts, robots, or hand carried in impervious containers. Carts must have a solid bottom shelf/barrier to protect supplies from wheel and floor contamination.

9. Hours of Operation Central Storeroom.

    a. The FCLO or designee shall compile a "locator list" of all items stocked by Logistics in the central storeroom and post it in a visible location. This locator list shall include for each item, at a minimum, the IMF number, item description, and location.

    b. If the central storeroom is not staffed 24 hours a day, 7 days a week, a security access card, code, or key will be provided to access the storeroom. A detailed procedure shall be posted with a log sheet or other process to instruct staff how to sign out equipment and supplies when inventory management staff is not present. The process will be monitored daily and will include the following:

(1) IMF number or item identifier

(2) Item description

(3) Quantity

(4) Item destination

(5) Personnel obtaining item including phone extension

(6) Time and date the item was removed from central storeroom

(7) Any other pertinent information

REQUIREMENTS FOR POINT-OF-USE

1. The primary objective of the POU program is to create a demand driven supply chain utilizing an integrated system of multiple devices designed to facilitate the efficient provision of materials and supplies to clinical staff. POU equipment must be linked (interfaced) with the VHA-approved inventory management system that allows all required data to be captured. This equipment provides secured storage of supplies close to where the supplies are used. Locally developed or Class III interface programs and changes to the VHA-approved interface program are prohibited.

2. Implementation of POU equipment for supply storage requires the same level of quality control that standard shelves do. Types of quality control mechanisms include conducting a weekly cleaning and expiration/outdate check, ensuring stock is rotated using FIFO, checking package integrity, cycle counting, and ensuring proper levels are set for items. Facilities using POU equipment must have a contingency plan in place in the event of a system and/or power failure.

    a. **Elements of the POU Program.** The focus of the POU program encompasses the equipment and actions associated with:

    (1) Receipt of supplies

    (2) Delivery of supplies to primary inventory locations (referred to as distribution points or DPs within software)

    (3) Replenishment at secondary inventory locations (referred to as points of use or POUs within the software)

    (4) Generation of replenishment documents, which are linked to IFCAP

    (5) Conduct cycle counts

    (6) Generate reports for the user

    b. **POU Equipment.** The POU system may consist of a variety of equipment, depending on the facility and its location. Equipment included with the POU program may include servers, Web-based software, touchscreen computers also known as kiosks, weight-sensing bins, overhead computer monitors, barcode printers, mobile handheld computers/scanners, and automatic dispensing systems. Specific POU equipment installed is based on consumption data and cost, with high consumption items being placed within equipment providing automatic replenishment information, such as weight-sensing bins, and high cost items placed in equipment with higher security, such as automatic dispensing equipment. The POU system equipment can also be used for remote clinics and in areas where supplies are prone to stock-outs or pilferage. POU equipment will be integrated with Web-based software, which will have a non-intrusive link with IFCAP through a VHA-approved program that allows all required data to be captured.

   c. **POU Return Bin(s).** Designated POU return bin(s) provide secure storage for unused clinical supplies that are removed from individual POU inventory storage bin/shelving/locations. In order to maintain accuracy of the inventory, clinical staff will not return items to weighted, or any other type, of inventory storage bins/shelving. Unused items may only be placed in a designated return bin(s) if they have not been opened, stored in a patient room, or exposed to event related contamination. All items placed in the designated return bin(s) should be examined by SCM staff for evidence of tampering or contamination prior to restocking. The return bin(s) will be emptied by SCM staff during the restocking process.