Report No. DODIG-2013-053 March 13, 2013

Inspector General
United States Department of Defense

Special Plans and Operations

Oversight of U.S. Military and Coalition Efforts to Improve Healthcare Conditions and to Develop Sustainable Afghan National Security Forces Medical Logistics at the Dawood National Military Hospital

Inspector General

United States Department of Defense

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INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350-1500

March 13, 2013

MEMORANDUM FOR SECRETARY OF DEFENSE
DEPUTY SECRETARY OF DEFENSE
COMMANDER, U.S. CENTRAL COMMAND
COMMANDER, INTERNATIONAL SECURITY ASSISTANCE FORCE/UNITED STATES FORCES-AFGHANISTAN
COMMANDER, INTERNATIONAL SECURITY ASSISTANCE FORCE JOINT COMMAND
COMMANDER, NORTH ATLANTIC TREATY ORGANIZATION TRAINING MISSION-AFGHANISTAN/COMBINED SECURITY TRANSITION COMMAND-AFGHANISTAN

SUBJECT: Oversight of U.S. Military and Coalition Efforts to Improve Healthcare Conditions and to Develop Sustainable Afghanistan National Security Forces (ANSF) Medical Logistics at the Dawood National Military Hospital
(Report No. DODIG-2013-053/Project No. D2012-D00SPO-0163)

We are providing this report for review and comment. This is the fourth in a series of reports published by the Office of Inspector General's Special Plans and Operations Directorate that focus on the development of a sustainable medical logistics and healthcare capability in support of the ANSF. We considered management comments on a draft of this report from International Security Assistance Force (ISAF), ISAF Joint Command and North Atlantic Treaty Organization (NATO) Training Mission-Afghanistan/Combined Security Transition Command-Afghanistan (NTM-A/CSTC-A) when preparing the final report.

DOD Directive 7650.3 requires that recommendations be resolved promptly. We request additional comments and information by April 12, 2013, as follows:

- Commander, International Security Assistance Force – Recommendation 1.a.
- Commander, ISAF Joint Command – Recommendation 1.a.
- Commander, NATO Training Mission-Afghanistan/Combined Security Transition Command-Afghanistan - Recommendations 1.a, 2.a, 2.b, 3.a, 4.a, 4.c, 5.b, 5.d, 6.a, 6.b, and 7.c.

If possible, please send your comments in electronic format (Adobe Acrobat file only) to spo@dodig.mil. Copies of your comments must have the actual signature of the authorizing official for your organization. We are unable to accept the /Signed/ symbol in place of the actual signature. If you arrange to send classified comments electronically, you must send them over the SECRET Internet Protocol Router Network (SIPRNET).

We appreciate the courtesies extended to the staff. Please direct questions to Ms Patricia Goodin at (703) 604-9485 (DSN 664-9485) or email to patricia.goodin@dodig.mil or patricia.goodin@dodig.smil.mil. If you desire, we will provide a formal briefing on the results.

Kenneth P. Moorefield
Deputy Inspector General
Special Plans and Operations

Executive Summary: Oversight of U.S. Military and Coalition Efforts to Improve Healthcare Conditions and to Develop Sustainable Afghan National Security Forces Medical Logistics at the Dawood National Military Hospital

Who Should Read This Report?

Personnel within the Office of the Secretary of Defense, the Joint Staff, the U.S. Central Command and its subordinate commands in Afghanistan, the Military Departments, and Agencies that are responsible for and engaged in efforts to develop the capability of the Dawood National Military Hospital (NMH) and an effective medical logistics system in support of the Afghan National Security Forces (ANSF) should read this report.

Background

During the fall of 2010, Department of Defense Office of Inspector General (DoD OIG) became aware of potential problems with the accountability and distribution of pharmaceuticals at the NMH and within the Afghan National Army (ANA), and management issues specifically at the NMH. Accordingly, the DoD OIG conducted several reviews[1] of the ANSF healthcare system, which included visits to NMH in 2010 and 2011.

Figure 1. Dawood National Military Hospital, Kabul, Afghanistan

Source: NTM-A

In November 2011, the Inspector General for the Department of Defense conducted a walk-through[2] of NMH as part of his annual official visit to Afghanistan. During this visit, he noted improvements at the hospital which included better cleanliness of the hallways and patient rooms, but said that there was still work to be done. Additionally, he expressed commitment to continued oversight and additional visits by DoD IG personnel to evaluate NMH's progress in achieving a sustainable medical logistics and healthcare capability.

[1] DODIG reports SPO-2011-007, "Assessment of U.S. and Coalition Efforts to Develop the Medical Sustainment Capability of the Afghan National Security Forces," released June 14, 2011 and 2012-083 and "Additional Guidance and Training Needed to Improve Afghan National Army Pharmaceutical Distribution" released May 7, 2012.
[2] The DoD Inspector General visited various departments within the NMH including the Pharmacy, Intensive Care Unit, inpatient wards and the Operating Suite speaking with hospital staff and several patients.

A DoD IG team, which included U.S. civilians and former and retired military medical personnel, visited the NMH in February and June - July 2012 to review the status of U.S. and Coalition efforts to improve the healthcare management and treatment of patients in the NMH, assess related sanitation conditions, and evaluate the medical logistics processes supporting operations at the NMH.

Results

This report is divided into two parts: (1) Notable Progress, and (2) Challenges. The report makes 7 observations and 16 recommendations. The results are discussed therein.

Part I: Notable Progress

The report notes 11 examples where progress had been made in the areas of planning; development of ANSF healthcare standards, including development of a tool to evaluate the hospital's achievement and compliance with these standards; focused pre-deployment training for U.S. medical advisors; and initiatives to improve the treatment of patients and the healthcare management at NMH, including hospital sanitation, accountability of staff, and medical logistics support.

Part II: Challenges

> *"Development of a professional medical corps will take time and constant nurturing" (*Source: Senior Official from Combined Joint Medical Branch, ISAF Headquarters, August 2012)

Although progress had been made since our previous visits in 2010 and 2011, and February 2012, International Security Assistance Force (ISAF), North Atlantic Treaty Organization Training Mission-Afghanistan (NTM-A), and ANA Medical Command (MEDCOM) continued to face challenges in sustaining effective healthcare operations and medical logistics for the NMH, as well as at other medical facilities within the ANA. Specifically, ISAF and NTM-A needed revised policies and procedures that ensured timely and informed decision-making regarding the transfer of ANSF patients from Coalition medical facilities to the NMH. Additionally, although improved, the control and security of medications in the NMH pharmacy required additional work to prevent theft and mismanagement of these medications. Furthermore, current practices at the NMH relating to the availability and utilization of essential medical equipment, including patient monitoring units, required improvement to ensure that this medical equipment was available for all patients that could benefit.

Additionally, although the overall numbers of ANA medical personnel increased over the past year, personnel shortages continued to affect the NMH, specifically in nursing and in the pharmacy.

ANA hospitals also lacked qualified medical equipment repair technicians to sustain effective medical equipment maintenance and repair programs. Although there were some improvements noted in this program effort at NMH, the company contracted to conduct an inventory of all medical equipment throughout the ANA was unable to do so because they did not have qualified technicians coupled with other deficiencies; therefore the contract was terminated. Students currently enrolled in the Bio-Medical Equipment Technician training program at the Armed

Forces Academy of Medical Sciences were expected to provide some technical relief once they completed phase 2 of their on-the-job training and graduate from the program in the 2nd quarter of FY 2013.

Finally, improvements were needed in the logistics system to ensure the reliable availability of disinfectants and other cleaning supplies necessary to properly sanitize the hospital and prevent the spread of infectious disease.

Subsequent Measures Taken by NTM-A/CSTC-A

Following our February and July 2012 fieldwork in Afghanistan, NTM-A/CSTC-A continued to develop healthcare management and improve operations at NMH and across the ANA healthcare system.

Specific actions and ongoing efforts that we observed or were informed of by NTM-A/CSTC-A included:

- NMH improved physical security of controlled medications in their pharmacy bulk storage room and implemented adequate inventory control measures in the pharmacy dispensary, which will deter mismanagement, theft and waste of pharmaceuticals.
- Continued cooperation and commitment by Coalition, ANSF and Government of the Islamic Republic of Afghanistan (GIRoA) officials to ensure that the ANA medical equipment Tashkil[3] includes only those items that are necessary, practical, and cost-effective to use, maintain, and replace.
- ANA and MEDCOM established a process to procure and distribute disinfectants and cleaning supplies rather than rely on donations. Additionally, disinfectants and other cleaning supplies, such as bleach, hand sanitizer, and hand soap were added to the Class VIII Authorized Stockage List for medical supplies, which would allow ANA MEDCOM to have better control over the availability and distribution of these supplies.
- NTM-A continued use of its Validation Tool to assess NMH progress and compliance with ANSF Healthcare Standards. The Command also focused mentoring efforts on those areas that had yet to achieve the appropriate readiness rating.

For detailed discussions of the foregoing observations and recommendations, please refer to the respective sections in the report.

Recommendations requiring management comment are listed in the table on the next page.

[3] The Tashkil describes the authorized strength and structure of an ANSF organization.

Recommendations Table

Office of Primary Responsibility	Recommendations Requiring Additional Comment/Information	No Additional Comments Required At This Time
International Security Assistance Forces	1.a	
International Security Assistance Forces Joint Command	1.a	
NATO Training Mission-Afghanistan (NTM-A)/ Combined Security Transition Command-Afghanistan (CSTC-A)	1.a; 2.a, 2.b; 3.a; 4.a, 4.c; 5.b, 5.d; 6.a, 6.b; 7.c	4.b; 5.a, 5.c; 7.a, 7.b

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Introduction

The North Atlantic Treaty Organization (NATO) International Security Assistance Force (ISAF) has responsibility for the development of the military and police forces of Afghanistan and their transition to an independent security role under the Government of the Islamic Republic of Afghanistan (GIRoA). ISAF's two main subordinate commands, ISAF Joint Command (IJC) and the NATO Training Mission-Afghanistan/Combined Security Transition Command-Afghanistan (NTM-A/CSTC-A), each have complementary roles and capabilities with respect to the development of the Afghan National Security Forces (ANSF)[4] and its supporting healthcare system.

After the fall of the Taliban in 2001, the U.S. and international Coalition forces developed a plan for creating a national security force that included a military healthcare system. Today, this healthcare system is comprised of several Afghan National Army (ANA) hospitals including the Dawood National Military Hospital (NMH), responsible for specialty medical care, which is located in Kabul, the capital of Afghanistan.

This is the fourth in a series of reports published by the Office of Inspector General's Special Plans and Operations (SPO) Directorate focusing on the development of a sustainable medical logistics and healthcare capability in support of the ANSF. This report is self-initiated and is particularly focused on the NMH.

Previous reports on this subject are listed in Appendix B. Summary of Prior Coverage and may be viewed at http://www.dodig.mil/spo/reports.html.

> *"Afghanistan, with a per-capita income of US $561, is among the least developed countries in the world with 70% of the population living in extreme poverty and health vulnerability. The social indicators, which were low even before the 1979 Soviet invasion, rank at or near the bottom among developing countries, preventing the fulfillment of rights to health, education, food and housing. Since the fall of the Taliban, important progress has been achieved in all sectors, but much remains to be done in order to reach a significantly strengthened social infrastructure, realize the rights to survival, livelihood, protection and participation ..."* (Source: World Health Organization Cooperation Strategy, dated May 2011)

Objectives

On April 25, 2012, the DoD IG announced the "Oversight of U.S. Military and Coalition Efforts to Improve Healthcare Conditions and Develop Sustainable Afghan National Security Forces (ANSF) Medical Logistics at the Dawood National Military Hospital (NMH)," (Project No. D2012-D00SPO-0163-000). The objectives of this assessment were to review the status of U.S. and Coalition efforts to improve the:

- healthcare management and treatment of patients in the NMH,

[4] Afghan National Security Forces (ANSF) refers to the military and police security forces in Afghanistan.

- related sanitation conditions at the NMH, and
- medical logistics processes supporting operations at the NMH.

Background

Beginning in the fall of 2010, Department of Defense Inspector General (DoD IG) personnel became aware of potential problems with the accountability and distribution of pharmaceuticals at the NMH and within the ANA. Additionally, a joint inspection conducted by the NTM-A and ANA Ministry of Defense Inspectors General in February 2011 identified deficiencies in the medical logistics support and healthcare capability at NMH. Accordingly, DoD IG conducted several prior reviews[5] of the ANSF healthcare system, which included visits to NMH in December 2010, February 2011, and in the fall of 2011.

Previous news media accounts[6] reporting on poor patient care conditions and mismanagement at NMH during 2010, as well as concerns expressed by U.S. Military medical advisors in 2011, continued to focus attention on whether conditions are improving at NMH.

In November 2011 the Inspector General for the Department of Defense conducted a walk-through[7] of NMH as part of his annual official visit to Afghanistan. During this visit, he noted improvements at the hospital which included better cleanliness of the hallways and patient rooms. Additionally, he expressed commitment to continued oversight and additional visits by DoD IG personnel to evaluate NMH's progress in achieving a sustainable medical logistics and healthcare capability.

Consequently, a DoD IG team from the Special Plans and Operations Directorate, which included medical personnel, visited the NMH in February and June - July 2012 to review the status of U.S. and Coalition efforts to improve the healthcare management and treatment of patients in the NMH, assess related sanitation conditions, and evaluate the medical logistics processes supporting accountable and controlled supply operations at the NMH.

ANSF Health Care in Afghanistan

One objective of Coalition efforts has been to partner with the ANA and Afghan National Police (ANP) to develop a healthcare delivery system able to provide for combat casualty care and rehabilitation of Afghan soldiers and police country-wide.

Today, there are six Afghan hospitals that support the ANSF. The ANP has one hospital located in Kabul, the capital of Afghanistan. The ANA has five hospitals; the 410-bed Dawood National Military Hospital in Kabul and 100-bed hospitals located in Kandahar, Gardez, Herat and Mazar-e-Sharif. There is a 6th ANA regional hospital under construction in Gamberi, Laghman Province. See the map on the next page displaying the locations of the ANA hospitals.

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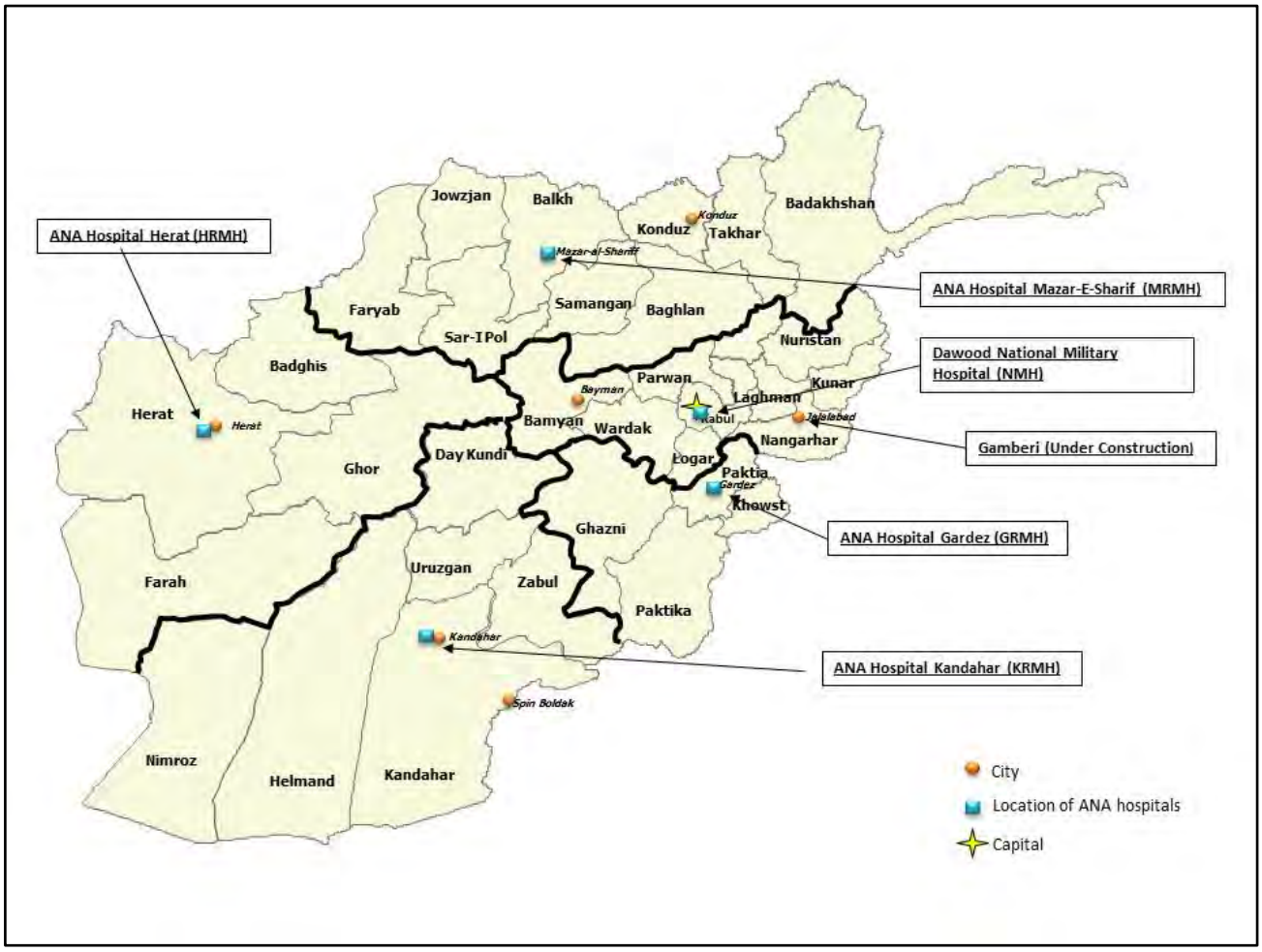
[5] DOD IG reports SPO-2011-007, "Assessment of U.S. and Coalition Efforts to Develop the Medical Sustainment Capability of the Afghan National Security Forces," released June 14, 2011 and 2012-083, "Additional Guidance and Training Needed to Improve Afghan National Army Pharmaceutical Distribution" released May 7, 2012.
[6] "At Afghan Military Hospital, Graft and Deadly Neglect", Wall Street Journal, published September 3, 2011.
[7] The DoD Inspector General visited various departments within the NMH including the Pharmacy, Intensive Care Unit, inpatient wards and the Operating Suite speaking with hospital staff and several patients.

Figure 2. Afghan National Army (ANA) Hospitals



Source: NTM-A

Dawood National Military Hospital

Built in the early 1970s by the Soviet Union, the NMH resides on a seven-acre medical campus that encompasses the eight-story hospital, an out-patient complex named the Polyclinic, the Armed Forces Academy of Medical Sciences, a garrison support facility, and a logistics complex that includes a recently constructed medical warehouse. The NMH is under the command of the ANA Surgeon General and is managed by an ANA Hospital Commander, and staffed by ANA medical personnel. As of July 2012, there were approximately 260 patients hospitalized in the NMH, the majority of whom were soldiers and police personnel and their families.

The hospital is responsible for the following services:

- Specialty Units: Intensive Care Unit (7 beds), Post-Operative Anesthesia Care Unit (3 beds), Operating Room (6 suites), Hemodialysis Unit (5 beds), Emergency Room, and an Endoscopy procedure area

- General Wards: Medical/Surgical (Orthopedic, Septic, Burns, Ear Nose and Throat, Neurology, Obstetrics/ Gynecology, Pediatrics, and Internal Medicine)
- Support Services: Pharmacy, Lab, Blood Bank, Physical Therapy, Preventive Medicine, Bio-Medical Equipment Maintenance and Repair, Logistics, and Mortuary Services

Figure 3. Dawood National Military Hospital

Source: DoD IG

Medical Training Advisory Group

The NTM-A Medical Training Advisory Group (MTAG) was established in November 2009 to provide medical advisors for assignment to every regional command and associated ANSF hospital in Afghanistan. These U.S. and Coalition military and civilian personnel included doctors, nurses, administrators, logisticians, and clinical services support and technical staff.

Their role has been to advise and train Afghan healthcare personnel on the provision of care to the Afghan sick or wounded on the battlefield, in the operating room, the intensive care unit, on the hospital wards, and at the supply depots. The MTAG has assisted in the management of the health care system and its logistical support, the supplies for which have been financed by U.S. Afghanistan Security Forces Fund (ASFF) and also provided by international donor contributions. MTAG advisors operate in close partnership with their Afghan counterparts during the performance of their duties.

At the time of the DoD IG team visit, there were 15 medical advisors assigned to the Medical Embedded Training Team in support of the NMH. Previously, there had been as many as 30 medical advisors assigned to NMH; however as part of the withdrawal of U.S. and Coalition Forces, the number of advisors were scheduled to decrease to 9 in FY 2013. The Commander, NTM-A/ CSTC-A, through the NTM-A/CSTC-A Command Surgeon, monitors and supports the activities of the mentors. As such, they prioritized the mentor's activities to focus on those areas required for NMH to transition to an independent role.

> *"Concentrate advising efforts in the enhancement of Leadership Development and Education and Training Lines of Effort. Incorporate Afghan Tier 1 Standards into the practice of continuous improvement and the development of a self-reliant, critical thinking, professionally-led ANSF medical staff."*
> MTAG NMH Mission Statement

PART I – NOTABLE PROGRESS

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The DoD IG has been engaged in providing ongoing oversight with respect to the U.S. Military and Coalition efforts to develop the Afghan military healthcare system, including the Dawood National Military Hospital (NMH), since 2008[8]. Specifically, we conducted five assessments, two criminal investigations and one audit. A description of the major findings from each project is summarized in Appendix C.

Working Toward Transition

An important goal of U.S. and Coalition forces in Afghanistan is to successfully transition security responsibility to the Afghan government. The continued development of an effective ANSF healthcare system, among other enabler functions, is critical to achieving success as the transition proceeds to 2014, and beyond. Through the efforts and leadership of ISAF, ISAF Joint Command (IJC), and NTM-A/CSTC-A working at all levels of the Ministry of Defense (MoD), Ministry of Interior (MoI), and Ministry of Public Health (MoPH), progress has been made in laying the foundation for building an effective ANSF healthcare system, including at Dawood NMH in Kabul, Afghanistan.

Development of Operational Plans

In 2008, DoD IG recommended in its report that the complexity of medical stabilization and reconstruction challenges in Afghanistan called for a robust U.S. interagency and international effort to assist deployed U.S. military medical personnel in developing and implementing a detailed, multi-year planning strategy. However, in 2010 ISAF had yet to develop along with the MoD an integrated operational plan to coordinate their joint efforts to build an effective ANA healthcare system.[9] The lack of effective joint planning resulted in uncoordinated and inconsistent efforts to develop ANA medical leadership and institutional capability.

ANSF Healthcare System Development Support Plan

ISAF, with input from IJC, NTM-A/CSTC-A, United States Forces-Afghanistan (USFOR-A) and ANSF leadership developed and published a medical transition plan in November 2011. The ISAF vision supporting this planning effort, and the ANSF Healthcare System development effort overall, was "quality warrior care, from point of injury through a professional, ethical, effective, and efficient medical system, to recovery and discharge, for the nation's defenders."

> *"By completing the 92 milestones by December 31, 2014, the transition plan's design will provide the ANSF with the training and resources to operate a military medical healthcare system that is self-reliant, adequate by regional standards, and capable enough to provide care for the entire ANA and ANP in their role of providing security to an independent Afghanistan, free of ISAF support."* (Source: Senior Official from Combined Joint Medical Branch, ISAF Headquarters, August 2012)

[8] "Assessment of Arms, Ammunition, and Explosives Control and Accountability; Security Assistance; and Sustainment for the ANSF" (SPO-2009-001), dated October 24, 2008 was the first DoD IG report to address the development of the Afghan military healthcare system. Other reports are listed in Appendix B.
[9] DoDIG report "Assessment of the U.S. Department of Defense Efforts to Develop an Effective Medical Logistics System within the Afghan National Security Forces" (SPO-2011-007), dated June 14, 2011.

The November 2011 transition plan, called the ANSF Health System Development Support Plan, contained a total of 92 milestones and decision points. Progress in implementing the 2011 transition plan is monitored through monthly Principals Group[10] and quarterly General Officer Steering Committee meetings with representation from ISAF, IJC, NTM-A, ANA and Afghan National Police (ANP) Surgeons General Offices, and the MoPH. According to ISAF, the milestones were deliberately front-loaded to the beginning of 2012 in order to generate momentum and allow flexibility if adjustments in future progress time-lines became necessary. (Refer to Appendix F: "ANSF Healthcare System Development Support Plan" for additional details of what is included in the ISAF plan.)

NTM-A/CSTC-A Medical Advising Plan

In support of the November 2011 ISAF plan for the development of the ANSF Healthcare System, NTM-A released their corresponding plan in January 2012 with a stated transition objective as follows:

> "An interdependent, professionally led-ANSF health function which generates and sustains sufficient police and army medical personnel, infrastructure, and logistics capabilities, with accountable and effective health services that support the ANSF."

The NTM-A plan defined five "lines of effort" (LOE) and relevant objectives which focused the efforts of U.S. and Coalition medical advisors as they assisted the ANSF medical forces to fully transition operations to Afghan lead by the end of 2014. Specifically, efforts focused on:

- LOE 1: Training and Education – Develop and implement the Warrior Care specialty producing programs in the ANSF
- LOE 2: Ministerial Development – Establish a functioning medical staff organization at MoD, MoI, ANA Medical Command (MEDCOM) and ANP Office of the Surgeon General (OTSG)
- LOE 3: Institutional Development – Develop institutionally coherent commands with the ANA MEDCOM and ANP OTSG
- LOE 4: Direct Provision of Healthcare – Established using Tier 1[11] Warrior Care standards for the ANSF
- LOE 5: Enabling Efforts for Transition – What ISAF, IJC and NTM-A/ CSTC-A must accomplish internally in order to enable the efforts of LOEs 1-4

Both ISAF and NTM-A recognized that in order to achieve success, ANA MEDCOM would have to partner with the ANP Office of the Surgeon General and the MoPH to create a single, accountable, effective, and enduring ANSF Healthcare System, one with sufficient resources to

[10] The Principals Group is a monthly forum where key leaders from the three ISAF medical headquarters (HQ ISAF Combined Joint Medical Branch (CJMED), IJC CJMED, and NTM-A Command Surgeon meet with the ANA and ANP Surgeons General, and one general officer level MoPH deputy, to discuss progress made on the ANSF Healthcare System transition plan.

[11] Tier 1 refers to the basic capabilities and functions of a healthcare system.

achieve ANSF Tier 1 healthcare standards within a larger GIRoA healthcare system with equivalent standards of care.

ANSF Healthcare Standards and Validation Tool

Decades of warfare and turmoil contributed to the inadequate development of Afghan military medical services. Consequently, U.S. and Coalition efforts to mentor ANSF medical personnel were focused on addressing these significant shortcomings.

In 2010, the DoD IG identified that the ANSF lacked clearly defined healthcare standards and end-state objectives that were needed to guide U.S. and Coalition mentoring efforts.[12] NTM-A's response to this reported finding resulted in the establishment of appropriate healthcare standards for the ANSF. Additionally, NTM-A developed a criteria-based survey tool to evaluate the progress of the Afghans in their compliance with the established healthcare standards.

ANSF Healthcare Standards

In 2010, NTM-A/CSTC-A awarded a contract to *CURE International*, a non-governmental organization (NGO), to develop operational and procedural standards for specific GIRoA hospitals. In 2011 the contractor tested the use of these standards at various ANSF hospitals, and they provided training to ANSF medical personnel on how to use and grade the standards.

The healthcare standards developed by *CURE International* used what was referred to as a "tiered" approach, whereby successive tiers represented a graduated measurement of healthcare capability based on defined standards and criteria. Specifically, Tier 1 standards demonstrated functions of a basic, self-sustaining healthcare system; Tier 2, a self-sustaining healthcare system with limited advance capabilities; and Tier 3 standards represented advanced capabilities including criteria to address medical professional credentialing and advanced certifications.

In April 2012 *CURE International* delivered their final product to NTM-A/CSTC-A. In coordination with ANA MEDCOM, these standards were adopted and are now referred to as the "ANSF Healthcare Standards." (See Appendix E for additional information and a listing of the focus areas for the established healthcare standards.)

> *"These independent assessments by NTM-A have also enjoyed unexpected corroboration as witnessed by the performance of several of these hospitals and their staff when reacting to recent mass casualty events in Afghanistan."* (Source: Senior Official from Combined Joint Medical Branch, ISAF Headquarters, August 2012)

NTM-A/CSTC-A Validation Tool and Inspections

In December 2011, NTM-A/CSTC-A developed an inspection checklist and survey tool using the criteria listed in the newly established ANSF healthcare standards. NTM-A/CSTC-A's Validation Team used the survey tool, referred to as the NTM-A Validation Tool, to assess a hospital's compliance with the Tier 1 healthcare standards.

[12] DoD IG report "Assessment of the U.S. Department of Defense Efforts to Develop an Effective Medical Logistics System within the Afghan National Security Forces" (SPO-2011-007), dated June 14, 2011.

Beginning in December 2011, the NTM-A/CSTC-A Validation team used the survey tool to inspect ANA hospitals, including the NMH. The team scored each hospital department and specific functional area by assessing their degree of compliance in meeting the relevant criteria for each standard. (See Appendix E for additional details and a summary of the NTM-A/CSTC-A Validation Team's results for all ANSF hospitals.)

NTM-A planned to use the Validation Tool to conduct quarterly assessments of all ANSF hospitals. Additionally, the NTM-A Validation team worked side-by-side with the ANA Validation Team from MEDCOM's Quality Improvement, Standards, and Metrics Division to conduct the required inspections during the second round of assessments that began in May 2012 and ended in October 2012. An NTM-A official reported that this joint effort was a success and supported the development of the ANA to continue their own inspections on a semi-annual basis and established independent institutional capacity to provide oversight of ANA medical operations.

Although the ANSF Healthcare Standards and Validation Tool were used by ANA MEDCOM and other ANA medical personnel, they were not codified in an MoD decree or related directive. Notwithstanding this fact, the team noted that ANA medical personnel use the ANSF Healthcare Standards as a means to determine what additional work is required to improve their ability to meet the established standards. NTM-A advisors indicated that they also use the ANSF Healthcare Standards and the results of the Validation Team's inspections to guide and prioritize their mentoring and advising efforts.

Capability Milestone Ratings and Readiness to Transition

According to a senior NTM-A official, three factors were used to determine the readiness of an ANSF hospital to transition to independent Afghan management: Infrastructure, Functionality (based on achieving Tier 1 of the ANSF Healthcare Standards), and Sustainability. Specifically, the NTM-A Validation Tool is used to assess compliance with the Tier 1 ANSF Healthcare Standards and was key in determining the level of functionality of a particular facility.

The scores derived from the Validation Tool were used to assess the level of compliance by individual hospital departments based on established standards. The scores were then compiled into a metric to determine a Capability Milestone (CM) rating for each area assessed, as well as an overall CM rating for the hospital. The CM ratings range from CM-1A to CM-4 and are based on the level of current capabilities that serve to forecast when the hospital will most likely be ready to transition to Afghan lead. A score of CM-1B is the stated goal for transition and indicates that a hospital is capable of executing functions with coalition oversight only. (See Appendix E for additional details on CM ratings and the results of the Validation inspections for all ANSF hospitals in 2012.)

Progress Noted in CM Ratings at NMH

NTM-A conducted its first inspection of NMH using the Validation Tool in January/February 2012. The second inspection was conducted in May 2012. According to NTM-A reports, NMH achieved a CM-1B rating in May 2012 which was a "significant improvement" compared to February 2012. This rating indicated that the hospital could accomplish its mission with minimal coalition assistance for continued performance and improvement. NTM-A reports recommended

that the NMH implement additional Standard Operating Procedures, improve training offered to the staff, and better organize specific departments. (Table 1 provides a comparison of the CM Ratings for the various departments within the NMH.)

Table 1. NMH Departmental Capability
Milestones (CM) Ratings - February 2012 and May 2012

NMH	Feb-12	May-12
Anesthesia	CM2B	CM2A
Bio-Medical Repair	CM2B	CM1B
Blood Bank	CM1B	CM1A
CSSD	CM2B	CM1A
Dental	CM1B	CM1A
Emergency	CM2B	CM2A
Facilities Management	CM2B	CM1B
Human Resources	CM1B	CM1A
ICU	CM2A	CM1A
Infection Prevention	CM3	CM1B
Internal Medicine	CM2A	CM1A
Laboratory	CM2A	CM1A
Leadership Council	CM1B	CM1A
MEDLOG	CM1B	CM1A
Nursing	CM2B	CM1A
Operating Theater	CM3	CM1A
Outpatient	CM2A	CM1A
Patient Administration	CM1B	CM1A
Pharmacy	CM2A	CM1A
Physical Therapy	CM1B	CM2A
Preventative Medicine	CM2A	CM2A
Radiology	CM3	CM1B
Ultrasound	CM3	CM1B
CT	CM3	CM2A
MRI	CM3	CM2A
Surgery	CM1B	CM1A
OVERALL RATING	CM2A	CM1B
Color-Coding is based on the level of CM rating with red as the lowest level of CM-4; Orange as CM-3; Yellow as CM-2B; and variations of green for CM-2A, CM-1B and CM-1A. CM1B is the goal to determine the readiness towards transition		
CM-4 indicates the institution cannot accomplish its mission.		
CM-3 indicates the institution cannot accomplish its mission without significant coalition assistance.		
CM-2B indicates the institution can accomplish its mission with some coalition assistance.		
CM-2A indicates the institution is capable of executing functions with minimal coalition assistance.		
CM-1B indicates the institution is capable of executing functions with coalition oversight only.		
CM-1A indicates the institution is capable of autonomous operations with reduced coalition oversight.		

Source: NTM-A

Specific Progress Observed at National Military Hospital

In accordance with the former DoD Inspector General's stated commitment to continue oversight of the NMH, we made an unannounced visit to the hospital in February 2012. We followed this by conducting a more detailed announced assessment in June - July 2012. During both events we interviewed U.S. medical advisors, NMH personnel, patients and their families, as well as toured several patient wards, the Intensive Care Unit, the pharmacy, and the medical logistics warehouse. A discussion of salient points and the progress we noted from previous visits to NMH are presented below. Other findings and their corresponding recommendations are addressed in Part II of this report.

Figure 4. DoD IG Analyst Reviewing Contents of Storage Room

Source: DoD IG SPO

Physical Environment and Sanitary Conditions at the Hospital

In general, the areas of the hospital we visited in February and July 2012 appeared neat and uncluttered. Although most supply closets on the patient wards we visited were clean and organized, a few were not. Several of the charge nurses took great pride in keeping their supply closets clean and orderly and did so regularly. Charge nurses on other patient wards were not as organized and claimed they needed additional storage shelves to properly organize their supplies.

NMH logistics personnel removed excess supplies and broken or unused medical equipment from the patient care areas. Once the excess supplies and equipment was collected the logistics personnel returned the unneeded equipment to ANA Logistics Command (LOGCOM) for re-issue to other commands. NTM-A advisors informed that 27 storage containers filled with excess items and equipment were properly inventoried, documented, and transferred to LOGCOM.

Figure 5. Supply Room on ANA Orthopedics Ward

Source: DoD IG SPO

During our July 2012 visit, the NMH Director for Administration

explained that he increased the number of housekeepers which made it easier to properly maintain the cleanliness of the hospital. We found that the hospital wards were properly stocked with Dettol (a disinfectant cleaner), Max (an abrasive powdered cleaner), and other cleaning supplies. Additionally we noted the housekeeping staff used the appropriate disinfectant solutions to properly clean the patient care areas. This was an improvement over our February 2012 visit during which we observed housekeepers mopping the floors with plain water because the proper cleaning supplies, including a disinfectant solution were not available. (See Observation 7, "Availability of Disinfectants" for a discussion on the unreliable availability of disinfectants.)

Figure 6. Disinfectants and Cleaning Supplies Available During July 2012 DoD IG Visit

Source: DoD IG SPO

Patient Care Conditions

In November 2010 the ANA MEDCOM instituted a patient bill of rights that established minimal standards for hospitalized patients.

The ANA Patient Bill of Rights addressed the following:

- entitlement to free medications,
- frequency of visits by physicians and nursing staff,
- cleanliness of the hospital including clean patient linens,
- clean bandages and frequency for changing,
- edible food including fruits and vegetables, and a
- physician's explanation of the patient's illness and intended treatment plan.

Figure 7. ANA Patient Bill of Rights Posted in NMH Hallway

Source: DoD IG SPO

In February and July 2012 we observed posters throughout the hospital displaying the patient bill of rights written in Dari with pictures representing the relevant information. (Appendix G contains a copy of this poster.) Although we did not see similar posters in the patient rooms, the NMH Chief of the Medical Staff explained that Patient Administration personnel presented and

reviewed the bill of rights with all patients when they were admitted to the hospital. Procedures were in place for the patient to sign and acknowledge their understanding of these rights upon their admission. Furthermore, the Chief of Nursing assigned a nurse to make daily patient rounds and question patients about whether their rights were being met, and, among other things, whether they were satisfied with the care they were receiving.

During our tour of the wards in July 2012 we interviewed numerous patients and their families to determine their understanding of the patient bill of rights and whether they believed their rights were being met. In all responses, patients and/or their family members replied positively. We observed that patients we interviewed had clean bed linens and pajamas, their bandages and dressings were clean and properly applied, and the patient rooms were tidy with clean floors, and ward bathrooms were clean. Furthermore, patients explained they received medications as ordered by their physician. All of the patients we interviewed stated that they did not pay for any medications or medical supplies that were used in their care.

Figure 8. Amputee Patient on Orthopedic Ward (clean sheets and clean bandages)

Source: DoD IG SPO

During both of our visits in February and July of 2012 we did not observe malnourished or neglected patients. U.S. medical advisors stated that patients at NMH were provided adequate care by ANA medical personnel given the conditions and current state of healthcare in Afghanistan. Additionally, NMH had implemented a nutritional services program to help address the challenge of caring for patients with complex medical conditions.

Actions and Accountability of NMH Personnel

Prior to our visits in 2012, there had been reports of ANA physicians and other personnel leaving work early to pursue other private employment opportunities. We did not see or hear evidence of this during our two visits. The NMH Commander implemented new reporting procedures in February 2012 to ensure accountability of hospital personnel. The NMH Chief of Nursing developed and implemented several policies and procedures to better account for the attendance and performance of patient care duties by nursing personnel. Both U.S. medical advisors and ANA NMH leaders expressed confidence that the newly appointed ANA Surgeon General was responsible and dedicated to improving the support and accountability of ANA medical personnel.

During our later visit in July 2012, we received no reports or complaints related to the attendance or accountability of NMH personnel. In fact, to enforce the policy changes, we were informed

that staff members had been disciplined and not paid when they were not at their assigned place of duty.

Medical Logistics Support

The Class VIII[13] Supply Warehouse on the NMH compound was completed in the fall of 2011 and became fully operational in 2012.

We found that the NMH medical logistics personnel participated in training on the logistics directives contained in MoD Decree 4.0.[14] Additionally, they were provided training to other NMH personnel who also were required to utilize the MoD logistics forms.

Figure 9. NMH Logistics Personnel Review Recently Developed Automated System Used to Account for Medical Supplies and Pharmaceuticals in the Warehouse

Source: DoD IG SPO

We observed that U.S. medical logistics advisors assisted NMH medical logistics staff in developing an automated system that enabled the Afghans to better account for medical supplies and pharmaceuticals in their warehouse. Although this automated system was only recently implemented, the Afghans were excited and proud to display the new technology and appeared eager to complete the required data entry. This system should enable NMH to completely automate inventory control measures for their medical supplies.

Allegations of Corruption and Inappropriate Behaviors at NMH

During our site visits in February and in July 2012, we did not receive any allegations of wrongdoing or corruption at NMH. U.S. medical advisors and NMH leaders reported that previous allegations of corruption, fraud, and other complaints at NMH had been reported by the Command and were being pursued by GIRoA authorities including the Attorney General's Office, National Directorate of Security (NDS), High Order of Oversight Anti-Corruption and the MoD.

To augment the ANA anti-corruption policy, the Chief of Nursing for NMH implemented an internal policy to allow nursing personnel to submit a complaint of wrongdoing to be considered by legal authorities and the Commander of NMH. Additionally in 2012, NTM-A implemented policy and procedures to facilitate medical advisors' ability to report any issues of concern relevant to their mission at the NMH. Our interviews with U.S. advisors and NMH personnel

[13] Medical material, including equipment and supplies, is referred to as Class VIII.
[14] MoD Decree 4.0 describes the common procedures, formats and forms for the communication of logistic information between supported activities and the supply and materiel management of the MoD.

indicated that they were aware of the respective NTM-A and NMH reporting policies and procedures.

Medical Advisor Pre-Deployment Training

In 2010 we found that pre-deployment training for medical advisors did not include specific training for the missions that they would perform. During our July 2012 visit NTM-A advisors explained that former members of the NTM-A Medical Training Advisory Group (MTAG) had provided personal insights into the medical mentoring program and suggested specific changes for inclusion in the pre-deployment training for medical advisors at Fort Polk, Louisiana. Discussions with current medical advisors indicated that an additional 2-week training program focused on the medical mentoring mission had been included in the Fort Polk training. Although the mentors we interviewed in July had only been in Afghanistan for a short period of time, their initial assessment of the value of the new training was positive.

> *"He (the new ANA Surgeon General) has introduced a sense of urgency into the development of the ANA medical service both at the hospital level and across the Army. He is energetic, inspiring to his people, and fearless in shaking up the status quo."* (Source: Senior Official from Combined Joint Medical Branch, ISAF Headquarters, August 2012)

In summary, we found that the recently developed ANSF Healthcare Standards established defined goals for the NMH as well as for the entire ANSF healthcare system. Additionally we observed that NMH had made progress in several key management and performance areas and that patients appeared well-cared for and satisfied generally with the care they were receiving. Part II of this report discusses some of the challenges that remained at the time of the inspection. Regardless of these challenges, new leadership at ANA MEDCOM and NMH appeared committed to continuing the progress towards meeting transition goals.

PART II – CHALLENGES

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Observation 1. Transfer of ANSF Patients from Coalition Hospitals to the ANA National Military Hospital

The decision-making process to determine whether and when ANSF patients will be transferred from Coalition hospitals to the NMH had not been established or properly coordinated.

This was due, in part, to the absence of a written policy and clear procedures between Coalition and ANSF medical facilities that established and standardized the conditions under which patients were transferred from one medical facility to another. Additionally, the NMH personnel assigned to coordinate the transfer of these patients did not have the requisite clinical skills to determine whether the NMH possessed the necessary clinical capability and capacity to properly care for patient.

As a result, the NMH accepted the transfer of ANSF and other Afghan patients, for whom they could not effectively provide proper medical care, putting the health and safety of these patients at risk. Furthermore, these acutely ill patients accepted for transfer required ANSF medical personnel to dedicate a disproportionate amount of time and hospital resources to the care of these patients, detracting attention from the needs of other patients in the NMH.

Applicable Criteria

Afghan National Security Forces (ANSF) Healthcare System Development Support Plan to COMISAF OPLAN 38302, dated November 28, 2011. This transition plan was developed by ISAF to guide Coalition efforts in their assistance to the ANSF in the development of their healthcare system. The transition objective for the ANSF was focused on Warrior Care[15], providing health support to the ANSF members from recruitment through discharge in both outpatient and inpatient settings.

NTM-A/CSTC-A BASEORD 2012-2014, "DCG Ops Command Surgeon," dated January 9, 2012. This plan was developed in response to ISAF's transition plan and identified the lines of effort and supporting objectives that NTM-A used to focus its advisory efforts for the development of the ANSF medical system.

ISAF Standard Operating Procedure HQ, 01149, "ISAF / Coalition Medical Rules of Eligibility," dated December 15, 2011. This procedure outlined and established a consistent statement of eligibility and entitlement to ISAF and Coalition Force medical care and transportation provision for patients and casualties within the Combined Joint Operational Area.

Discussion

The primary objective of the ISAF/Coalition medical mission is to provide medical treatment and force health protection to ISAF/Coalition Forces. ISAF policies direct that "Humanitarian

[15]ISAF defines 'Warrior Care' as caring for the ANSF member from recruitment throughout his time in the ANSF which includes care aimed at the prevention of ill health, and treatment of any illness or injury while serving.

law and medical ethics oblige all medical services to provide emergency care in cases where life, limb or eyesight would be jeopardized without immediate intervention." As such, ANSF personnel and other Afghan civilians (Local Nationals) who were injured and/or sick have regularly been brought to Coalition medical facilities for evaluation and treatment.

Another objective of the ISAF/Coalition medical mission is to enable "an Afghan to care for an Afghan." In support of this mission to further develop the ANSF healthcare system, ISAF/Coalition medical professionals must determine when it is appropriate to transfer an Afghan patient from an ISAF/Coalition medical facility to an Afghan facility. Given that the NMH is identified as an Echelon IV[16] medical facility, it serves as the main referral center receiving Afghan patients transferred from Coalition hospitals and other ANSF regional hospitals.

> *"Quality warrior care, from point of injury through a professional, ethical, effective and efficient medical system, to recovery and discharge, for the nation's defenders."*
> ISAF's vision for the development of the ANSF Healthcare System

Concerns Expressed by ANA Surgeon General

During our fieldwork the Command Surgeon for ISAF Joint Command (IJC) and U.S. Forces – Afghanistan (USFOR-A) shared that the ANA Surgeon General had concerns that some Afghan patients had been transferred from Coalition hospitals to NMH inappropriately. The ANA Surgeon General had said that several patients died soon after their transfer to NMH and that their medical condition may have been too critical to be properly treated at NMH. He was concerned that these patients were transferred when the NMH did not have the requisite level of medical equipment and personnel to care for these patients at that point in their treatment and recovery.

The ANA Surgeon General presented information to the IJC Command Surgeon asserting that in a two-month period ISAF/Coalition medical treatment facilities transferred 137 patients (110 ANA soldiers, 17 Afghan National Police (ANP), and 10 civilians) to the NMH. Of these patients, 13 (1 ANA, 3 ANP and 9 civilians) later died of their wounds. The ANA Surgeon General asked for assistance from the IJC Command Surgeon to review relevant information on those patients who had died.

IJC Review

After review of the available information[17], the IJC Command Surgeon determined 12 patients who died soon after they were transferred to the NMH were suffering from wounds which were

[16] Afghan run healthcare facilities are identified as Echelon II through Echelon IV. Echelon II facilities exist at the ANA Troop Medical Clinics and ANP Regional and Provincial Clinics and offer primary care as well as initial damage control and stabilization of trauma prior to hospital transfer. Echelon IV capabilities include those offered at the lower echelons of care as well as advanced care such as specialist surgical and medical services, increased ICU capabilities, preventive medicine, dentistry, eye care, inpatient neuropsychiatry, advanced diagnostic services to include CT and MRI, full physical rehabilitation, and capacity for convalescence.

[17] Medical records for 12 of the 13 patients in question were available at the time of the IJC review.

likely to be fatal, and would not have survived no matter where they were transferred and the level of care that was made available to them.

The IJC Command Surgeon explained that although these patients were transferred based on established ISAF policies and procedures, he believed that the capacity and clinical capability of the NMH might not have been fully considered when the decision to transfer was made. Furthermore, he concurred that more needed to be accomplished to ensure the proper coordination of care for ANSF patients transferred to the NMH and other GIRoA medical facilities.

Notwithstanding the goal and desire for continued development of the ANSF healthcare system and the end-state of Afghans caring for and managing the treatment of their own injured or wounded from the point of injury until recovery, the IJC Command Surgeon commented that these war-related catastrophic injuries presented a great challenge to the Afghans. He stated that the ANSF medical personnel did very well given their training, experience, and medical equipment available to them. He explained that certain resources found in western hospitals were not available in the Afghan hospitals, using as an example ventilator support. The NMH did not have the same ventilator equipment and supplies that were available in the Coalition hospitals. Due to an immature but developing medical logistics system, the NMH, at times, lacked the required expendable medical supplies such as ventilator tubing to make them effective.

Current ISAF and MEDCOM Policies/Practices

Current ISAF policies provided for the medical treatment of ANSF and Afghan civilian patients in ISAF and Coalition Forces medical treatment facilities, but did not identify in sufficient detail the criteria to be applied for determining the suitability of Afghan patients for transfer to the local Afghan healthcare system.

Figure 10. DoD IG Analyst Speaking with ICU Staff

Source: DoD IG SPO

The Ministry of Defense did not have a policy pertaining to the transfer of Afghan patients from Coalition medical treatment facilities to GIRoA healthcare facilities. Notwithstanding the lack of a written policy, the ANA Medical Command and NMH established a practice of using an English-speaking Afghan liaison officer to serve as the single point of contact to coordinate planned patient transfers to the NMH. This individual, however, did not have the clinical acumen necessary to ensure that the NMH was capable of providing the necessary clinical services support for these critically injured patients being considered for transfer.

In summary, the decision-making process regarding patient transfers from Coalition facilities to the NMH was lacking and may have jeopardized the health and recovery of some patients. The ANA medical personnel assigned to coordinate the transfer of patients from other medical

facilities to the NMH did not have the requisite clinical skills to determine whether the NMH had the necessary clinical capability to properly care for patients. As a result, the NMH received ANSF and other Afghan patients for whom they could not effectively provide the proper medical care, putting the health and safety of these patients at risk.

Recommendations

1.a. ISAF, in coordination with IJC, NTM-A, MoD-Health Affairs and the ANA Surgeon General, develop and implement policy and procedures that guide the transfer of patients between Coalition and other GIRoA medical facilities. These policies should be applicable to the Coalition medical facility when they transfer a patient, and to the GIRoA medical facility that would receive the transferred patient. Additionally, these procedures should include a determination that addresses the acuity of the patient, and ensures that suitable ANA medical personnel and the appropriate medical equipment are available prior to the transfer of the patient.

Management Comments

ISAF, IJC and NTM-A/CSTC-A concurred with Recommendation 1a. NTM-A/CSTC-A noted that ISAF, in conjunction with MoD-HA, ANA SG, MoPH, Afghan National Police Surgeon General and Coalition medical facilities would continue to develop and refine policy and procedure guidelines as Casualty Evacuation (CASEVAC)/Ground Evacuation procedures were validated.

Our Response

ISAF, IJC and NTM-A/CSTC-A's comments to Recommendation 1.a were partially responsive. We request a timeline for the development and revision of policy and procedure guidelines governing the transfer of patients between Coalition and other GIRoA medical facilities. Additionally, please provide a copy of the CASEVAC/Ground Evacuation procedures that are currently undergoing validation as they apply to the transfer of patients to the NMH.

Observation 2. Controls in the Pharmacy

The inventory of pharmaceuticals[18] in the NMH pharmacy dispensary room was not managed effectively. Specifically, the pharmacy did not employ necessary manual or automated inventory accountability methods and controls in the dispensing area.

Additionally, controlled substances[19] were stored in the NMH pharmacy bulk storage room in a small container that was not secured to the wall or the floor.

This was due primarily to the lack of clear and concise policies and standard operating procedures (SOPs) for the control of pharmaceuticals. MEDCOM did not identify specific inventory control procedures for pharmacy dispensary areas, nor were adequate levels of control defined to ensure the security of controlled substances.

As a result, the lack of controls in the NMH pharmacy dispensary area and improper security measures for the storage of controlled substances could result in mismanagement, theft, and waste of pharmaceuticals.

Applicable Criteria

MEDCOM policy dated Solar Year 1391 "Policy Regarding Control of Medications." This policy provided guidance pertinent to accountability and control measures in ANA pharmacies to prevent waste and misuse of medications. Specifically, it addressed the stocking and control of medications, distribution of medications to eligible patients, and required accountability reports.

ANA National Military Hospital, Kabul "Policies and Procedures of the Pharmacy Department" Revised Solar Year 1391. This manual described the policies and procedures pertinent to the pharmacy at NMH. Specifically, under "Security", the procedures required that medications and consumables be kept in a locked area, and that controlled substances are kept in a separate locked area. Additionally, under "Organization of Storage Areas", the procedures described that each item's storage location is clearly labeled with its contents and a stock card that contains a running tally of the balance of medication present.

Discussion

The pharmacy at NMH was comprised of two adjacent rooms. One room served as the bulk storage area and contained a 60-day supply of the authorized stockage list (ASL) of the Class VIII pharmaceuticals including controlled substances such as narcotics. The pharmacy dispensary was located in the second room and contained a five-day supply of all medications (approximately 10 percent of the pharmacy ASL).

[18] Pharmaceuticals pertain to items in a pharmacy and medicinal drugs

[19] A controlled substance is any drug or therapeutic agent, commonly understood to include narcotics, with a potential for abuse or addition, which is held under strict governmental control, as delineated by the Comprehensive Drug Abuse Prevention and Control Act passed in 1970.

The pharmacist used the smaller quantities of medications in the dispensary room to prepare and dispense medications for valid physician prescription orders. The supply of medications in the bulk storage room was used to re-stock the medication bins in the dispensary room to maintain the appropriate quantities for a five-day supply.

Inventory Control Measures

Inventory control procedures in the bulk storage room included the use of index cards to identify the name and quantity of available medications. The pharmacist updated these cards according to the quantities of medications that were added subsequent to supply orders received, or removed based on what was needed to restock the dispensary room. Monthly, the pharmacist conducted a review ensuring that the inventory was properly reconciled with the required MoD supply forms. According to an NMH pharmacist and his advisor, this new system improved the accountability and inventory control procedures in the bulk storage room of the pharmacy.

Figure 11. Use of a Manual Inventory Control System in the Bulk Storage Area of the Pharmacy

Source: DoD IG SPO

The dispensary section of the pharmacy, however, did not employ such a system of manually accounting for the quantity of medications and updating their inventory as the stock levels were depleted. It was unclear which, if any, inventory control procedures were used in the pharmacy dispensary.

The NMH Pharmacy SOP manual identified that pharmacists were responsible for the inventory and accountability of pharmaceuticals; however, this SOP manual did not provide the necessary detail to ensure that the proper steps for inventory control were followed in all areas of the pharmacy.

Subsequent to our visit, NTM-A provided additional information that NMH took corrective action and implemented the same inventory control measures in the pharmacy dispensary that were in place in the bulk storage room.

Figure 12. Implementation of Inventory Control System in the Pharmacy Dispensary - September 2012

Source: NTM-A

Control and Security of Controlled Substances

Based on recommendations from a DoD IG audit on ANA pharmaceutical distribution, NMH implemented changes in how they store and secure controlled substances. They removed the controlled pharmaceuticals from the open shelves in the pharmacy bulk storage room where they were previously stored with uncontrolled pharmaceuticals. Additionally, NMH obtained a storage locker to store their controlled pharmaceuticals and locked the container per their regulations.

Figure 13. Storage Container for Controlled Substances – July 2012

Source: DoD IG SPO

During our visit in July 2012 we found that the controlled substance storage locker, although an improvement over the previous method of storing controlled substances, was not properly secured to the floor or wall. The new storage locker was small enough that it could be easily lifted and carried away by two personnel.

Current MEDCOM policy and NMH policies and procedures identified that the security of controlled medications was required. However, these policies did not provide enough detail to describe the adequate measures necessary to prevent theft of the controlled substances. The policies should describe the required containers or storage areas and the means by which to physically secure the controlled substances.

Figure 14. Installation of New Storage Container for Controlled Substances – Sept 2012

Source: NTM-A

Subsequent to our visit, NTM-A explained that NMH took action to improve the physical security of the controlled substances container. NMH Pharmacy personnel transferred the controlled substances into a large, lockable filing cabinet and then, using screws and bolts, physically secured the filing cabinet to the storage shelving in the pharmacy bulk storage room.

These procedures appear effective as a measure in deterring the theft of narcotics and other controlled substances. Additionally, the drawers in the filing cabinet allowed for the medications to be stored separately and simplified the monthly inventory process.

In summary, the lack of effective guidance led to ineffective procedures for accounting and reconciling pharmaceuticals in the NMH

dispensary and securing controlled substances in the pharmacy bulk storage room. Although steps were taken to improve the pharmacy's methods for inventory control, MEDCOM and NMH policies required updating to codify procedures for inventory control and physical control of controlled substances.

Recommendations

2.a. NTM-A, in coordination with MEDCOM and NMH, ensure that policy is established to identify appropriate inventory control measures for each area where medications are stored including pharmacy storage rooms, dispensing areas and patient wards.

2.b. NTM-A, in coordination with MEDCOM and NMH, ensure that policy guidance is established to clearly define the proper security measures for controlled substances, including the appropriate storage container and physical means to secure the container.

Management Comments

NTM-A/CSTC-A concurred with Recommendation 2.a noting that they were working with MEDCOM and NMH to develop a Pharmacy SOP that contained inventory control measures for medications stored in the Pharmacy Dispensing Room, Pharmacy Depot, Pharmacy Duty Room, and Hospital Wards. Specifically, the practices defined in the SOP included the use of stock cards to maintain running tallies of shelf inventory, limiting personnel access, maintaining Ward logbooks, and specifying the periodicity of taking inventory.

NTM-A/CSTC-A concurred with Recommendation 2.b noting that action was completed and that current policy clearly outlined inventory control through the use of MoD forms, stock cards, and logs. Additionally, the conduct of regular inventory verifications and unannounced inspections and security of controlled substances including personnel access and escort lists and locked depots, dispensing rooms, and cabinets were also addressed in current policy. Furthermore, additional protective vaults and narcotic cabinets were requested via NATO funding to better secure the controlled medications.

Our Response

NTM-A/CSTC-A's comments to Recommendations 2.a and 2.b were responsive. We request a copy of the revised Pharmacy SOP including the new inventory control measures for medications stored in the Pharmacy Dispensing Room, Pharmacy Depot, Pharmacy Duty Room, and Hospital Wards when completed. Additionally, we request that in six months, NTM-A/CSTC-A provide a copy of the controlled substances inventory verification reports and results of recent unannounced inspections confirming that procedures were followed to ensure that controlled substances were properly secured.

Observation 3. Pharmacy Personnel Shortages

The National Military Hospital (NMH) did not have a sufficient number of pharmacists to properly dispense medications and manage the pharmacy.

This is due, in part, to the demands placed on NMH pharmacists to manage the 60-day authorized stock list (ASL) for 518 Class VIII pharmaceuticals and non-pharmaceutical medical consumables. Additionally, there were an inadequate number of pharmacists at NMH compared to the ANA regional hospitals.

Consequently, a shortage of pharmacists impacted the ability of NMH to safely and effectively dispense medications. Specifically, the lack of pharmacists impacted their ability to conduct proper quality control measures that were necessary for the effective ordering, receipt, and control of pharmaceuticals. Additionally, a shortage of pharmacists placed a burden on the remaining pharmacy personnel limiting their ability to conduct training for the medical and nursing staff at NMH.

Applicable Criteria

Afghan National Army – Approved Tashkil - 1391 National Military Hospital – Personnel. This document is the approved Afghan National Army personnel authorization for the NMH for the current solar year 1391. It provided detailed authorization by paragraph/line numbers, rank, military occupational skill, additional skill identifier(s), position, and required strength, by department.

NTM-A/CSTC-A "Standards for ANA Hospitals – Pharmacy." This document provided a listing of standards and criteria for the Pharmacy Department that was developed for ANA hospitals. The criteria are varied and labeled as Tier One, Tier Two and Tier Three, based on increasing levels of healthcare complexity.

NTM-A/CSTC-A "Validation Standards for ANSF Hospitals: Pharmacy." A rating tool that provided standards and criteria used to evaluate a department's performance according to Tier One of the ANSF Healthcare Standards for pharmacy departments.

Standards for the pharmacy department include the following:

- manning and organization of the department,
- Standard Operating Procedures including procedures to maintain a formulary, dispense medications to outpatients, prepare inpatient medication orders, and inventory and control measures for pharmaceuticals, and
- ordering, accepting delivery, and stocking of pharmaceuticals.

Discussion

The 1391 Tashkil identified a total of 10 personnel for the NMH pharmacy including 5 pharmacists, 4 pharmacy assistants, and 1 data entry clerk. Of the five pharmacists; one served

as the director of the Pharmacy, two served as Quartermasters[20] and two were Dispensing Pharmacists[21] who were involved with the dispensing of medications and other pharmacy duties to include inventory, checking expiration dates, establishing medication usage and consumable supply rates and professional training for pharmacy department personnel. See below for a listing of authorized position on the 1391 Tashkil for the NMH Pharmacy.

Table 2. 1391 Tashkil for NMH Pharmacy

Rank	MOS	Position	Required	Authorized
LTC	85AO5	Pharmacist (Compound Mix)	1	1
MAJ	86AO4	Pharmacist (Accountant)	1	1
MAJ	86AO4	Combined Medicinal Pharmacist	1	1
CPT	85AO3	Pharmacist (Quartermaster)	1	1
1LT	85AO2	Pharmacist (Quartermaster)	1	1
G5	86AE5	Pharmacy Assistant (Supply)	2	2
G5	86AE5	Pharmacy Assistant	2	2
R7	85AO2	Data Entry Clerk	1	1

Source: 1391 Tashkil for NMH

Impact of Pharmacy Personnel Shortages

At the time of our visit, the NMH Pharmacy Director and the NTM-A Pharmacy Advisor stated that additional pharmacists were needed to ensure the proper operation of the pharmacy at NMH. Additionally, an NTM-A Validation Team inspecting the NMH in May 2012 identified a need for additional staff in the pharmacy.

During our tour of the patient wards in July 2012, we found several expired medications that were brought to the attention of one of the NMH pharmacists. He explained that the pharmacy was understaffed, but that additional pharmacists would ensure that a pharmacist was available to make rounds in patient care areas where they could check for expired medications, among other things.

He also added that he was asked to provide training to both the medical and nursing staff, but was unable to do so due to the limited time he had available after

Figure 15. ANA Nurse Explaining Medication Cart

Source: DoD IG SPO

[20] A pharmacy quartermaster is a trained pharmacist who supervises the receipt, storage, and issuing of medications, equipment and consumable supplies and is responsible for organizing the pharmacy depot and establishing stock levels of medications and consumable to meet the current needs of patients.
[21] The Tashkil does not identify a pharmacist specifically as a dispensing pharmacist; however, any pharmacists can be used to dispense medications.

completing his primary duties.

Nursing staff should be responsible for checking medication expiration dates prior to administering the drug to a patient. However, this may not always be done and puts patients at risk of receiving expired medications. Using pharmacists in patient care areas to check for and discard expired medications is an additional control measure to ensure patients receive effective medications.

Subsequent to our visit, an NTM-A advisor explained that the NMH added two hospital personnel to serve as pharmacy technicians to augment pharmacy operations. Although adding staff to the pharmacy can assist with staffing shortages, these additional staff members were not trained as pharmacists and could not dispense medications, thereby offering little relief to the current pharmacists' workload.

Duties of Pharmacy Personnel

Dispensing Pharmacists were responsible for the dispensing of high quality medications and ensuring that medication was not wasted due to improper selection or use. Specific duties include the following:

- fill inpatient and outpatient prescriptions using the five rights of medication administration (right patient, right drug, right dose, right route, and right time/frequency for administration),
- ensure dispensed medications are of adequate quality and within the expiration date,
- ensure appropriate packaging of medications,
- record all medications dispensed and received,
- provide medication counseling, and
- provide professional training for pharmacy department personnel.

The Pharmacy Quartermaster duties included, among others, ordering and managing the inventory of the authorized stockage listing (ASL) of 518 Class VIII pharmaceuticals and non-pharmaceutical medical consumables. Additionally they were responsible to manage a 60-day supply of Class VIII pharmaceuticals in the pharmacy bulk storage area and a 5-day supply in the pharmacy dispensary.

According to an NTM-A official, the number of items in the ASL for Class VIII pharmaceuticals increased from previous years, thereby increasing the workload of the Pharmacy Quartermaster.

Although dispensing medications was not identified as one of the duties of a Pharmacy Quartermaster, we did observe the quartermaster dispensing medications and counseling patients at the time of our visit. This was likely due to increased workload demands on the Dispensing Pharmacist.

Comparison of ANA Pharmacy Requirements

An NTM-A advisor explained that there were an inadequate number of pharmacists at NMH compared to the other ANA regional hospitals.

The ANA has four Role 2/Echelon III level[22] regional hospitals and each hospital has a pharmacy with 3 pharmacists authorized according to the 1391 Tashkil. Although the regional hospitals were authorized 100-beds they typically averaged an occupancy rate of 30 patients each.

The NMH is a Role 3+ / Echelon IV level with a capacity of 410 inpatient beds and has an average occupancy of 255 patients. NMH was authorized five pharmacists according to the 1391 Tashkil.

The number of pharmacists authorized for each hospital was based on the number of authorized beds and not on the average occupancy or patient census. Although the NMH has a much higher average patient census, the number of pharmacists authorized does not appear proportionate to the number of patients when compared to the regional hospitals. See below for a comparison of pharmacists to the number of inpatient beds at each ANA hospital.

Table 3. Comparison of ANA Hospital Size and Number of Pharmacists Authorized by Location

Hospitals	Authorized # of Beds	Average # of Inpatients	Pharmacists Authorized
NMH	410	255	5
Gardez	100	30	3
Mazar-e-Sharif	100	30	3
Herat	100	30	3
Kandahar	100	30	3

Source: DoD IG SPO

The higher patient volume and pharmacy workload placed increasing demands on NMH pharmacy staff. Additionally, NMH policy and procedures limited dispensing responsibilities to the Dispensing Pharmacist, of which there were only two. Although we observed a Pharmacy Quartermaster assisting in the dispensing of medications, the logistical duties of the quartermaster were all-encompassing and their time should be focused on Pharmacy policies and procedures which are dedicated to the receipt, storage, issuing and accounting of medications.

In conclusion, we believe there were insufficient pharmacists at NMH and that this shortage hindered pharmacy operations. Additionally, the lack of available pharmacists could adversely affect the safety and health of patients receiving medical care at NMH. An increase in the number of pharmacists at NMH would provide the means to ensure that medications are properly

[22] Role 1 – 3+ / Echelon II-IV healthcare facilities provide medical care with ascending degrees of complexity. Role 1 / Echelon II level is provided at ANA Troop Medical Clinics and ANP Regional and Provincial Clinics with a focus on preventive health care and primary care as well as initial damage control and stabilization of trauma patients prior to hospital transfer. Role 2+ / Echelon III level is administered at ANA Regional Military Hospitals and the ANP Hospital in Kabul. These facilities provide the triage, resuscitation, emergency surgery and post-operative management services to manage trauma in an effort to treat patients until return to active duty or further stabilize patients for evacuation to the next echelon. Role 3+ / Echelon IV level is administered at the ANA's NMH in Kabul. Capabilities include all those offered at lower echelon facilities as well as advanced care including specialist surgical and medical services, increased ICU capabilities with dialysis, preventive medicine, dentistry, eye care, inpatient neuropsychiatry, full physical rehabilitation and capacity for convalescence.

dispensed and that adequate time is available to provide training as previously requested by the medical and nursing staff.

Recommendations

3.a. NTM-A, in coordination with MEDCOM and NMH, re-assess and validate the number of pharmacists and pharmacy personnel that are necessary to support the effective and efficient operation of the NMH pharmacy. Additionally, identify and implement interim measures to ensure that qualified personnel are available to meet the current workload demands in the NMH pharmacy.

Management Comments

NTM-A/CSTC-A concurred with comment to Recommendation 3.a. They acknowledged that higher patient volume and pharmacy workload placed increasing demands on NMH Pharmacy staff. Additionally, an insufficient number of pharmacists hindered pharmacy operations and had the potential to adversely affect the safety and health of patients receiving medical care at NMH.

NTM-A/CSTC-A noted that the proposed 1392 Tashkil showed an increase from five pharmacists to seven when combining Armed Forces Academy of Medical Science (AFAMS) pharmacy staff into functional personnel assets in both NMH and AFAMS. Although the addition of two pharmacists would alleviate some of the demands, a comprehensive analysis of hospital operations determined that the NMH pharmacy required ten pharmacists to provide full pharmaceutical services including after-hours coverage. NTM-A/CSTC-A stated that this recommendation was forwarded for consideration to MEDCOM. Additionally, they noted that Pharmacists in the next graduating class from Kabul Medical University were slated to fill ANA positions. Furthermore, there were processes available to recruit Pharmacists from the civilian sector.

Our Response

NTM-A/CSTC-A's comments to Recommendation 3.a were partially responsive. We request additional information regarding what interim measures are in place to ensure that qualified personnel are available to meet the current workload demands in the NMH pharmacy. Additionally, we request that NTM-A/CSTC-A provide a timeline and assignment location for the graduating Pharmacists from Kabul Medical University that are slated to fill ANA positions.

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Observation 4: Nursing Personnel Shortages

Nursing personnel shortages in certain patient care areas at the National Military Hospital (NMH) could have affected the delivery of safe and effective patient care. Specifically, the number of nurses assigned and available to work in a particular patient care area may not have been adequate to provide the nursing care necessary to promote a patient's healing and recovery.

This is due, in part, to a shortage of nursing personnel that existed throughout the ANA. Additionally, NMH lacked a specific policy and/or procedure to allow the Chief of Nursing to distribute the nursing staff between patient care areas. Such a policy would allow for the re-allocation of available nursing personnel to a ward or other patient care area where there was a greater demand for the nursing services.

Nursing personnel shortages at NMH and the inability to re-allocate nurses based on patient care demands could adversely affect the delivery of healthcare and result in a delay in a patient's recovery or in worsening of their health status.

Applicable Criteria

Afghan National Army – Approved Tashkil - 1391 National Military Hospital – Personnel. This worksheet is the approved Afghan National Army personnel authorization for the NMH for the current solar year, 1391. It provided detailed authorizations by paragraph/line numbers, rank, military occupational skill, additional skill identifier(s), and position and required strength, by department.

NTM-A/CSTC-A, "Validation Standards for ANSF Hospitals." This document provided a listing of standards and criteria used to evaluate a department's performance according to Tier One of the ANSF Healthcare Standards.

Discussion

In 2011 DoD IG reported that ANA medical personnel shortages limited the availability of medical services to ANSF personnel and hampered the development of an effective, sustainable ANA healthcare system. Additionally a 2011 MoD IG report identified that NMH nurses were "working long hours and there were too few nurses working on some wards which could lead to patient neglect."

Nurse Staffing at NMH

In July 2012 we noted that several of the busiest patient-care wards continued to experience nursing personnel shortages. The current Tashkil at the NMH had a thirty percent increase in nurse authorizations over the past two years; yet the number of authorized nurses on-hand was just over sixty percent. Although improved, the previous reported nursing shortages still exist. See Table 4 for a comparison of on-hand nurses with authorized nurses at NMH for the current and past year.

Table 4. Comparison of On-Hand Nurses vs. Authorized Nurses at NMH

	Nurses		
Solar Year	On Hand	Authorized	Percentage
NMH SY1391 *	130	206	63.10%
NMH SY1389 **	81	157	51.60%

* SY1391 Tashkil and assignment information provided by ANA GS G-1, through MTAG and was current as of 09 JUL 12

** SY1389 Tashkil and assignment information provided by the ANA GS G-1 and was current as of 10 OCT 10

Source: DoD IG SPO

Although a few NMH nursing departments were staffed at 100 percent, the majority of departments were staffed well below half their required strength. As such, patients were at risk of not receiving the level of nursing care that was required for their treatment and recovery

Table 5. Comparison of Nursing Personnel Numbers in Various Departments at NMH

	Nurses		
Department	On Hand	Authorized	Percentage
Orthopedics Nursing: Ortho-A & Ortho-B	14	32	43.80%
Operating Theatre Nursing	10	30	33.30%
PACU / ICU Nursing	13	25	52.00%
Emergency Room Nursing	10	25	40.00%
Thoracic Surgery Nursing	6	16	37.50%
General Surgery Nursing	6	15	40.00%
Plastic and Burn Nursing	6	13	46.20%
Top 7 Department by Authorization *	**65**	**156**	**41.70%**

* SY1391 Tashkil and assignment information provided by ANA GS G-1, through MTAG and was current as of 09 JUL 12; the top seven (respective of authorization) of 24 nursing departments are listed in this chart.

Source: NTM-A

Prolonged Working Hours

In July 2012, the NMH Chief of Nursing identified that one of his top three challenges was the shortage of nursing personnel and the high number of hours they worked. He explained that some nurses worked 32-36 hours straight and that the number of hours worked needed to be reduced.

The NMH was required to provide nursing coverage 24 hours/day and the lack of government transportation assets limited transportation options for those nurses covering the evening and night shifts. Nurses assigned to work overnight started work at eight o'clock in the morning and continued working overnight and through the next day shift until they were dismissed at four o'clock in the afternoon for a total of 36 hours.

The continually overworked nursing staff can become exhausted, make mistakes, and provide poor quality care. Additionally, these working conditions could result in patient maltreatment and/or neglect, whether intentional or unintentional.

Limited Options to Better Utilize Available Nurses

The nursing personnel shortages at NMH and the prolonged working hours for nurses covering the evening and night shifts hindered management's ability to adequately staff the hospital. One solution would be to cross-level available staff. Some departments in the NMH had more staff than other sections. Additionally, some patient care areas had a higher patient census[23] and were busier than other areas. Shifting nurses from an area with lower demand to an area that is understaffed could help to address this problem.

Cross-leveling or reallocation of the nursing staff at the NMH was not witnessed during our visit in July 2012. We noted that 45 patients were present on the Orthopedic Ward (mostly war-related injuries) and had 6 nurses assigned to fill the 13 available nursing positions (46.2% of authorizations). Additionally, the Ear, Nose and Throat (ENT) ward had seven patients with three nurses assigned to fill three authorized positions (100% of authorizations). Cross-training nursing staff to work in various patient care wards (Orthopedics, ENT, Intensive Care Unit) would permit for the re-allocation of the nursing staff by the Chief of Nursing and/or his representative based on needs of a particular unit.

Other Factors to Consider

In May 2012, Validation Teams from NTM-A and ANA MEDCOM conducted a joint inspection of the NMH. By their report, nursing had improved their overall rating to a CM-1A, which is the highest possible. However, there was no mention made of any difficulties in how the hospital performed in determining nursing staffing levels based on census and acuity levels, which is a specific criteria to be measured in the Validation Tool. It would seem appropriate that in future inspections the validation teams should include consideration of whether the limited numbers of nurses are best utilized in the patient care areas that have the highest demand for nursing services.

Furthermore, NTM-A/CSTC-A advisors commented that MEDCOM was working on defining the role of nursing. As explained by a senior medical advisor, "…the definition/scope of practice of nursing is varied and ill-defined, as such a 'nurse' on the Tashkil encompasses over twenty positions from 'nurse housekeepers' to the more traditional nurse as understood in western medicine. This continues to skew data somewhat and until this is addressed, the true extent of the nursing shortage is a moving target." Accordingly, within the last four to six months a proposed definition and job description for nursing was forwarded to MEDCOM for consideration. Once this definition is approved, the Tashkil will undergo a revision and include a more accurate picture of the number of true nurses (per the approved definition) required to meet the NMH and MoD mission.

In summary, although improved, overall nursing personnel shortages continued to affect NMH's ability to provide safe and effective patient care. In addition, ANA MEDCOM and the NMH

[23] Patient census refers to the number of patients occupying a bed on a patient ward.

lacked policy guidance that would allow for the cross-leveling of available nursing personnel based on patient acuity and census. This deficiency hindered leadership's ability to build on performance, evaluate and instill quality of care, and build the required or desired expectation of nursing programs and operations.

Since our site visit and feedback provided to the NMH Commander and his advisor on July 3, 2012, MEDCOM has been developing a policy to support cross-leveling of nursing personnel within the NMH. Additionally, further coordination, between the MEDCOM Advisor and the ANA Recruiting Command (ANAREC) was underway for developing a policy or action letter on activities to assess current recruiting practices and to identify and implement measures to fill current nursing vacancies from the NMH Tashkil.

Recommendations

4.a. NTM-A, in coordination with MEDCOM and NMH, ensure that policy is established to allow for the cross-leveling of nursing personnel based on workload demands within the NMH.

4.b. NTM-A, in coordination with MoD Health Affairs and MEDCOM, ensure that the Tashkil identifies the appropriate type and number of nurses required at NMH according to the MEDCOM nursing definitions. Additionally, ensure that current recruiting practices are reviewed and identify and implement measures to fill current nursing vacancies in the NMH Tashkil.

4.c. NTM-A, in coordination with MEDCOM, consider the addition of criteria to the Validation Tool which would allow for the MEDCOM inspectors to evaluate whether the NMH is able to shift nursing resources based on patient census and patient acuity.

Management Comments

NTM-A/CSTC-A concurred with Recommendation 4.a noting that the NMH Chief of Nursing reported that most departments were now staffed well, ranging from 84.6% - 150% and that his current policy and procedures allowed for the cross-leveling of nursing personnel to any specific ward or patient care area according to demand.

Additionally, NTM-A/CSTC-A concurred with Recommendation 4.b and noted that recommended actions were accomplished. According to the NMH Chief of Nursing and Coalition Senior Nurse Mentor, current overall percentage of authorized Tashkil 1391 is 86.63% of which the top seven departments by authorization were primarily over 100% filled (with three at 86.6%, 90% and 93%). Additionally, all nursing personnel had specific written job functions and descriptions, and undergo semi-annual and annual evaluations as well as verification of nursing credentials and certificates. The NMH Chief of Nursing agreed that one of his main challenges was ensuring continuity in his nursing staff as nurses retire or resign. Furthermore, NTM-A/CSTC-A noted that current recruiting practices were under review by MEDCOM to address gaps in nursing personnel.

NTM-A/CSTC-A concurred with comment to Recommendation 4.c clarifying that MEDCOM was moving away from a strict Validation Tool and utilized survey methods instead to determine

the effectiveness of hospital practices and processes. This survey method would address adequacy of staffing in meeting nursing needs relative to patient census and acuity.

Our Response

NTM-A/CSTC-A's comments to Recommendation 4.a, 4.b, and 4.c were responsive. For Recommendation 4.a , we request a copy of the 1391/1392 nursing authorizations to include the number of nursing personnel assigned to each department. Additionally, please provide the number of authorized beds and corresponding average patient census for each ANA/ANP inpatient ward so that a comparison can be made between the numbers of nurses assigned to work a particular inpatient ward and the average patient census. Finally, we request that NTM-A/CSTC-A provide a copy of the NMH Chief of Nursing policy and procedure specific to the cross-leveling of nurses.

For Recommendation 4.b we request that NTM-A/CSTC-A provide an update on the review of ANA nursing recruiting practices and the status of filling nursing vacancies at the NMH in six months.

For Recommendation 4.c we request that NTM-A/CSTC-A provide a description of the survey methods used by MEDCOM to assess the adequacy of NMH staffing in meeting nursing needs relative to patient census and morbidity. Additionally, in six months, we request NTM-A/CSTC-A provide an update on the adequacy of NMH nursing staffing using the results of NTM-A's Validation Tool and associated MEDCOM survey.

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Observation 5. Medical Equipment Repair and Maintenance Capability

Medical equipment repair and maintenance capability had improved at the NMH but still required further development. Furthermore, this capability was insufficient and needed improvement within other areas of the ANA healthcare system including ANA regional hospitals and clinics.

This was due primarily to the lack of qualified ANA medical equipment repair technicians. Although Coalition forces had assisted the ANA in establishing Bio-Medical Equipment Technician (BMET) training at the Armed Forces Academy of Medical Sciences (AFAMS), the program was in its infancy.

Additionally, a contract for medical equipment repair and maintenance awarded to a private Afghan company in September 2011 failed to achieve results. This contract was intended to bridge the gap until ANA BMETs graduated from AFAMS and were available to serve as medical equipment repair technicians. However, the contractor did not provide the qualified personnel necessary to serve as biomedical engineers who, therefore, were unable to conduct the maintenance and repair of ANA medical equipment as required by the contract.

As a result, the ANA lacked sufficient personnel to maintain and repair the medical equipment at ANA hospitals and clinics, compromising the provision of safe and effective patient care.

Applicable Criteria

DoD 6010.13-M "Medical Expense and Performance Reporting System for Fixed Military Medical and Dental Treatment Facilities Manual," April 7, 2008. The manual defines biomedical equipment repair as a function that provides preventive maintenance, inspection, and repair of medical and dental equipment.

Specific responsibilities of the biomedical equipment repair service included the following:

- conduct a systematic inspection of equipment to determine operational status and assign serviceability condition codes to equipment,
- perform scheduled preventive maintenance of medical and dental equipment,
- repair or replace worn or broken parts,
- rebuild and fabricate equipment or components, and
- modify equipment and install new equipment.

MoD Decree 4.0 "Supported and Supporting Unit Logistics Policy and Support Procedures," January 2009. This decree established logistics policy and procedures for the ANA as a basis for introducing, modernizing and integrating the ANA logistical system with NATO military logistics doctrine. Specifically, Section 2-1 discussed maintenance as a logistics function.

NTM-A/CSTC-A "Standards for ANA Hospitals." This document provided a listing of standards and criteria for 22 departments and/or sections that were developed for ANA

hospitals. The criteria were varied and labeled as Tier One, Tier Two and Tier Three, based on increasing levels of complexity of the criteria and standards.

NTM-A/CSTC-A "Validation Standards for ANSF Hospitals - Biomedical Engineering." A rating tool that provided standards for Biomedical Engineering based on an early version of ANSF Tiered Healthcare Standards. The standards contain a listing of criteria that was scored and used to determine the Capability Milestones rating for the Biomedical Engineering department of a hospital.

Discussion

In June 2011, the DoD IG reported[24] that it was imperative for ANA hospitals to have a functioning medical equipment repair program to ensure that required equipment was properly maintained and available for patient care. The report identified that the ANA lacked sufficient number of BMETs and that medical equipment was not being properly maintained throughout the ANA. Although we noted improvements in the ANA's ability to properly maintain and repair medical equipment during our July 2012 visit, problems persist.

Armed Forces Academy of Medical Sciences (AFAMS) Biomedical Equipment Technician (BMET) Training Program

NTM-A/CSTC-A in coordination with ANA MEDCOM initiated a BMET training program at AFAMs in March 2011. The first class of 20 BMETs was expected to graduate in the first quarter of 2013.

Although initially designed as a 12-month training program, the student's initial poor literacy and mathematical skills resulted in extending the length of the training program. Specifically, additional training was provided in literacy programs and learning the English language to ensure that BMET students could understand the medical equipment reference manuals, written in English.

The BMET training program consisted of two phases: Phase 1 included a 12-month period of didactic training at AFAMs, and Phase 2 consisted of a 6-month on-the-job training program, which was offered at the NMH and other ANA regional hospitals. Twenty BMET students completed Phase 1 in June 2012 and were presently engaged in Phase 2. Half of these students were assigned to NMH for their Phase 2 training and were supervised by ANA biomedical engineers. The remaining 10 students were assigned to the ANA regional hospitals.

An NTM-A BMET advisor commented that BMET students were currently enrolled in the Phase 2 portion of their training and were doing well in the on-the-job training portion of the curriculum.

Medical Equipment Repair and Maintenance Program at NMH

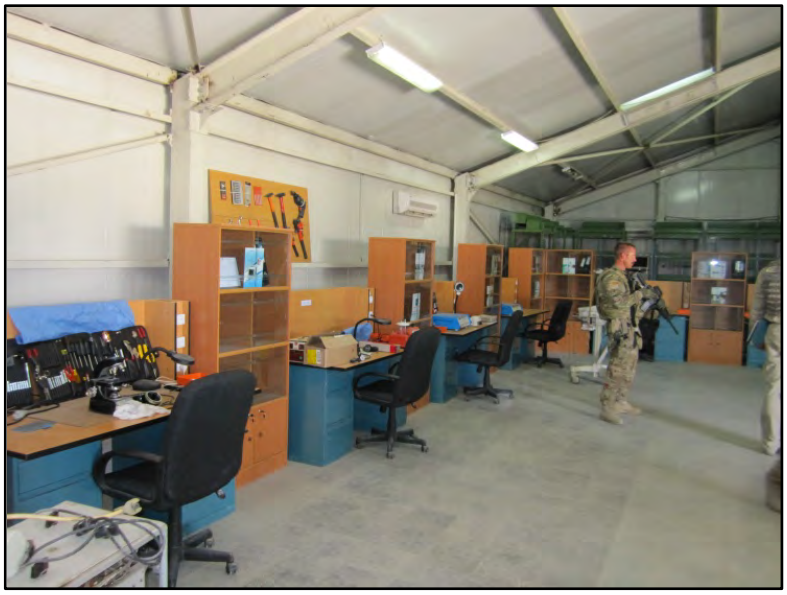
In July 2012, there were four biomedical engineers authorized on NMH's 1391 Tashkil with four ANA personnel filling the positions (1 supervisor and 3 technicians). These ANA personnel

[24] "Assessment of the U.S. Department of Defense Efforts to Develop an Effective Medical Logistics System within the Afghan National Security Forces," released June 14, 2011 (Report No. 2011-007).

were trained in India and had received biomedical engineering as well as English language training.

The departmental supervisor explained that NMH required four additional biomedical technicians for a total of eight. This requirement was under consideration by MEDCOM and reportedly would be included in the 1392 Tashkil. As stated earlier, there were also 10 ANA BMET students in Phase 2 training at the NMH who were assisting with maintenance and repair functions.

Figure 16. NMH Bio-Medical Engineering Department



Source: DoD IG SPO

The biomedical repair facility at NMH was located in a building adjacent to the Medical Logistics Warehouse on the NMH compound. The repair shop measured approximately 40 feet x 120 feet and was divided into two sections. Most of the space was an open bay with workshop repair benches and tools, storage shelving and a storage area with broken medical equipment that was awaiting repair or removal. The remainder of the space was a combined conference room/ office and library containing medical equipment repair manuals. The facility appeared clean and neat and was not cluttered with broken medical equipment.

Figure 17. Medical Equipment Reference Manuals

Source: DoD IG SPO

Lack of Qualified Personnel May Impact Patient Safety

Figure 18. Free-standing Compressed Gas Cylinders Found at NMH in July 2012

Source: DoD IG SPO

In July 2012, we observed several free-standing large cylinders that were used to store compressed oxygen in patient care areas. The NMH did not have built-in oxygen lines and therefore bedside cylinders were used to deliver oxygen to needy patients. However, the free-standing oxygen cylinders posed a safety hazard. A physical means to secure the cylinders, such as chaining them to the wall or storing them in an upright stand, would prevent them from falling and causing potential damage or injury to patients and hospital personnel. A fully functioning and capable biomedical equipment repair department could implement safety controls to prevent such hazards from occurring.

Biomedical Engineering Capability Milestone Ratings at the NMH

The NTM-A/CSTC-A Validation Team conducted two assessments of NMH's medical equipment repair program using the Biomedical Engineering standards. See below for a summary of these results.

Table 6. NTM-A/CSTC-A Validation Results for NMH Biomedical Engineering

BIOMEDICAL ENGINEERING	Overall CM rating	0	1	2
January 2012 (26 elements scored)	CM-2B	5	9	12
May 2012 (24 elements scored)	CM-1B	6	3	15
Scoring: 0 (no evidence of compliance), 1 (evidence of compliance, however they are inconsistent in performance), 2 (evidence of consistent compliance)				

Source: DoD IG SPO

In a May 2012 visit, the NTM-A/CSTC-A Validation Team reported that it worked alongside the ANA Validation Team from MEDCOM Quality Improvement, Standards, and Metrics Division in inspecting the hospital. The Medical Equipment Repair department achieved a rating of CM-1B, demonstrating that this department was effective in achieving Tier 1 of the Biomedical Engineering standards with Coalition oversight only.

Bridge Contract for Medical Equipment Repair and Maintenance Support

The CSTC-A initiated a contract to provide medical equipment repair and maintenance support as an interim measure anticipating that graduating BMETs could eventually fulfill this function.

The contract was awarded to a private Afghan company in September 2011 and was intended to provide the following:

- scheduled and unscheduled maintenance for specific medical equipment,
- service of broken equipment to include repair parts,
- calibration of equipment and upgrades as needed,
- Preventive Maintenance Inspections (PMI),
- quality assurance and safety programs and warranties exercised where appropriate, and
- documentation and tracking of all manufacturer identified recall actions.

The contractor failed to adequately perform the required work as defined in the Performance Work Statement (PWS). Qualified repair technicians were not hired, maintenance documentation was not maintained, and accountability of repair parts was not documented.

The U.S. Central Command Joint Theater Support Contracting Command (Forward), Kabul Regional Contracting Center in Camp Eggers, Afghanistan issued a Cure Notice[25] to the contractor on January 28, 2012. This notice identified the areas of non-performance that required immediate action. The contractor was unable to correct the identified deficiencies and consequently was issued a Show Cause Notice[26] on July 16, 2012. An order was issued to the contractor to stop work on July 19, 2012.

Personnel Requirements for Medical Equipment Repair and Maintenance Program for ANA Regional Hospitals

Although the scope of this particular report was focused on the NMH, the impact of problems with the medical equipment repair and maintenance support contract was experienced and observed ANA-wide. There was noticeable improvement in ANA command emphasis to rectify BMET and biomedical equipment shortfalls; however, progress had been slow. Repairs were made by available ANA personnel with available repair parts under Coalition supervision and assistance. However, deficiencies continued since the ANA had been unable to fill all of their biomedical engineering positions. See below for the status of the number of ANA personnel assigned to fill positions in Biomedical Engineering Departments at ANA regional hospitals and other commands.

[25] A Cure Notice is issued to a contractor when the government believes that the contractor's performance of the contract is in jeopardy. A specific period of time is given to the contractor to correct any deficiencies that were identified in the Cure Notice.
[26] A Show Cause Notice is issued to a contractor when the government is considering terminating the contract.

Table 7. Comparison of Authorized Positions vs. Fill Rates for ANA Biomedical Engineering Departments

Biomedical Repair Staffing	NMH	MEDCOM	AFAMS	Herat	Kandahar	Mazar-e Sharif	Paktiya (Gardez)	Total
BMET Repairmen Authorized on 1391 Tashkil	3	4	0	1	3	1	1	13
BMET Repairmen Filled on the 1391 Tashkil	3	1	1*	0	0	0	0	5
BMET Repairmen in Training	8	0	0	3	3	3	3	20
Other Positions Authorized on 1391 Tashkil**	9	8	2	3	6	3	4	35
Other Positions Filled on 1391 Tashkil**	3	4	1	0	0	0	0	8
*The approved 1391 Tashkil did not identify a requirement for AFAMs however a technician was placed there to support the BMET training program.								
"Others" include individuals who do not serve as BMET repairmen such as Department Chiefs, administrative assistants, quartermasters, administrative non-commissioned officers and others								

Source: DoD IG SPO

Capability Milestone Ratings for Biomedical Engineering at ANA Hospitals

The lack of qualified ANA medical equipment repair technicians and the problems noted previously has adversely impacted the likelihood of a successful transition in 2014. A Capability Milestone (CM) rating of CM-1B is the acceptable standard to determine departmental readiness for transition. Although the NMH successfully achieved a CM-1B rating for their medical equipment repair department, the other ANA regional hospitals did not. See below for a comparison of CM ratings for all ANA hospitals.

Table 8. NTM-A/CSTC-A Capability Milestone (CM) Ratings for Biomedical Engineering

BIOMEDICAL ENGINEERING	NMH	Herat	Kandahar	Mazar-e Sharif	Paktiya (Gardez)
December 2011 – February 2012	CM-2B	CM-4	CM-4	CM-2B	CM-4
June 2012 – October 2012	CM-1B	CM-1A	CM-4	CM-2B	CM-4
CM-1A: Capable of autonomous operations					
CM-1B: Capable of executing functions with Coalition oversight only					
CM-2A: Capable of executing functions with minimal Coalition assistance; only critical ministerial functions are covered					
CM-2B: Can accomplish its mission but requires some Coalition assistance					
CM-3: Cannot accomplish its mission without significant Coalition assistance					
CM-4: The department exists but cannot accomplish its mission					

Source: DoD IG SPO

In summary, the NMH had made some improvement in their medical equipment maintenance and repair program. However, the organic capability of the ANA to maintain and repair medical equipment remains limited due to the lack of qualified personnel.

Figure 19. Workbench for Bio-Medical Repair Technicians at NMH

Source: DoD IG SPO

CSTC-A reported that it intends to re-bid the contract for medical equipment maintenance and repair. However, this will likely result in an award no sooner than the second quarter of fiscal year 2013. In the interim, personnel shortages and the lack of a medical equipment maintenance contract will challenge the ability of MEDCOM leadership to provide an effective medical equipment maintenance and repair program which, in turn, may impact the ANA's ability to provide safe and effective patient care.

After our visit to the NMH, we found improved cooperation among key leaders within the Coalition, ANSF and GIRoA during the ANSF Healthcare Shura,[27] sponsored by ISAF on July 17-18, 2012. ANA leaders discussed the need for the ANSF to assess, validate, and update the MEDCOM's Tashkil medical equipment lists, cross-level operational equipment where possible, and ensure that the ANSF purchase, or obtain by donation from Coalition and NGO sources only the equipment that is necessary, practical, and cost effective to use, maintain and replace. For example, the Afghan leaders in the Shura agreed that durable modern mechanical hospital beds would be more useful than sophisticated multi-purpose electronic hospital beds; likewise, simple bedside ventilators would be more desirable for the NMH than the installation of an integrated computerized central medical gas distribution system. These more practical approaches would more effectively support the continued development and sustainment of the ANA's healthcare system.

[27] "Shura" is an Arabic word meaning "consultation". In Afghanistan, meetings involving Afghan and Coalition leaders are referred to as a shura.

Recommendations

5.a. NTM-A/CSTC-A, in coordination with MEDCOM, develop a plan which ensures that NMH and other ANA hospitals have a viable medical equipment repair program.

5.b. NTM-A/CSTC-A expedite contracting efforts to ensure that there is executable medical equipment maintenance and repair capability throughout the ANA.

5.c. NTM-A/CSTC-A, in coordination with MEDCOM, ensure that graduating BMET technicians are assigned to ANA hospitals based on priorities and needs of the current medical equipment repair programs.

5.d. NTM-A/CSTC-A, in coordination with MEDCOM, ensure that medical gas containers and cylinders are properly secured to the floor or wall to prevent them from falling.

Management Comments

NTM-A/CSTC-A concurred with comment to Recommendations 5.a and 5.c noting that the first class of 20 biomedical equipment technicians was expected to graduate the first quarter of 2013. They further clarified that the biggest challenge with the training program was the student's lack of basic literacy and mathematics skills. Thus, a program that was originally a year long, was now stretched to two years to include basic education and English language training. Once the training was completed in February 2013, the graduating biomedical equipment technicians would be equally distributed to four per ANA regional hospital.

NTM-A/CSTC-A concurred with Recommendation 5.b and noted that NTM-A and ANSF were actively engaged in establishing a medical equipment maintenance contract owned and managed by the ANA (assisted by NTM-A advisors) to maintain their medical assets. The NTM-A Finance officer submitted the contract requirements to ANA medical leadership on December 23, 2012. However, NTM-A/CSTC-A acknowledged that there would be challenges in finding a contractor with enough medical equipment technicians with the required skill sets.

NTM-A/CSTC-A concurred with Recommendation 5.d noting that the MEDCOM Validation Team now inspects for compliance on proper securing of tanks/cylinders as part of their Validation Tool for Facilities.

Our Response

NTM-A/CSTC-A's comments to Recommendation 5.a and 5.c were responsive. We request that NTM-A/CSTC-A provide an update on the ANA Tashkil including biomedical equipment repair positions authorized and positions filled for NMH and each ANA regional hospital in six months. Additionally, we request NTM-A/CSTC-A provide an update regarding any plans for additional biomedical equipment repair training at AFAMS.

NTM-A/CSTC-A's comments to Recommendation 5.b were partially responsive. We request NTM-A/CSTC-A provide additional information on a proposed timeline to execute a medical equipment maintenance contract. Given the absence of a viable contract, we also request that

NTM-A/CSTC-A provide a summary of interim measures that are in place to ensure that ANA hospitals, including NMH, have viable medical equipment maintenance and repair programs.

NTM-A/CSTC-A's comments to Recommendation 5.d were partially responsive. We request that NTM-A/CSTC-A provide an update on what action was taken by NMH to ensure that all free-standing medical gas containers and oxygen cylinders were properly chained to the wall or stored in an upright stand.

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Observation 6. Availability of Essential Medical Equipment

A sufficient quantity of essential medical equipment, such as intravenous pumps, suction machines, patient monitors, and vital sign machines, was not always available in patient care areas when needed.

This was because NMH personnel explained that some equipment was not functioning properly and needed repair. Additionally, hospital personnel were not aware that needed medical equipment was available in other departments due to an incomplete inventory of NMH medical equipment. Furthermore, NMH did not have an established policy or procedure that supported using available medical equipment in more than one patient care area.

As a result, the quality of patient care was adversely impacted. Additionally, existing medical equipment was underutilized.

Applicable Criteria

ISAF "Afghan National Security Forces (ANSF) Healthcare System Development Support Plan to COMISAF OPLAN 38302," dated November 28, 2011. This plan identified the focus areas, transition objectives and lines of operation for the ANSF and Coalition as they worked towards transition to Afghan lead. Specifically, the plan stated that a medical equipment inventory is required and incorporated into Tashkils no later than 2012.

Afghan National Army (ANA) – Approved Tashkil - 1391 National Military Hospital – Equipment. This document is the approved ANA equipment authorization for the NMH for the solar year 1391, which was current during the time of our visit. The document included a listing of equipment by type, item name, and quantity relevant to individual departments at the NMH.

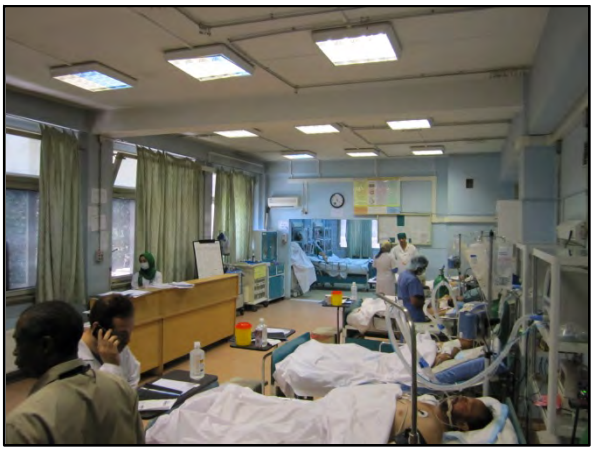
NTM-A/CSTC-A, "Standards for ANA Hospitals." These healthcare standards were developed in support of establishing a minimum standard for the operations of the ANSF healthcare system. They applied to 22 departments and/or sections pertinent to ANSF hospital operations. The criteria was varied and labeled as Tier One, Tier Two and Tier Three, based on increasing levels of complexity of the criteria and standards.

NTM-A/CSTC-A, "Validation Standards for ANSF Hospitals: Intensive Care Unit." A rating tool developed to provide standards and criteria used to evaluate departmental performance according to Tier One of the ANSF Healthcare Standards for Intensive Care Units. This document included, among other things, criteria that require that an Intensive Care Unit (ICU) has functional equipment to provide care to critically ill patients.

Discussion

The ICU at the NMH had critical medical equipment items that the nurses asserted were inoperable. They explained that they had 20 patient monitors, of which only 12 were

Figure 20. Intensive Care Unit at NMH



Source: DoD IG SPO

functioning. The monitors were operational but missing pulse oximeter[28] cables and were fully functional in other monitoring modes. The ICU staff also reported that of ten vital signs machines three were not functioning and that the Bio-Medical Repair department was aware of the problem. The nurses did not indicate that they had attempted to locate the needed medical equipment in other areas of the hospital. Cross-leveling such equipment throughout the hospital in order to fill critical medical equipment shortages on wards such as the ICU offered a unique opportunity for NMH leadership to address shortfalls.

Limited Medical Equipment Repair Capability at NMH

During the May 15, 2012 validation of the ICU at NMH, the NTM-A Validation Team also found deficiencies with medical equipment sustainability and noted that "broken equipment was not getting repaired." The inspecting team reported that only three of eight ICU beds had a functioning suction machine available at the bedside. They also noted that some equipment was "broken for weeks/months". The criteria used by the Validation Team to evaluate NMH's compliance with the ANA healthcare standards identified that essential medical equipment deficiencies required correction within eight hours.

Figure 21. Medical Equipment Awaiting Repair or Disposal

Source: DoD IG SPO

Consequently, the ICU at the NMH scored low during the inspection due in part to the limited availability of functioning equipment to provide critical care to the most seriously ill patients. Observation 5 provides additional detail and recommendations based on our finding of the limited medical equipment repair capability throughout the ANA, which hindered the ability of NMH to effectively support their own medical equipment.

Incomplete Medical Equipment Inventory

The ISAF ANSF Healthcare System Development Support Plan identified that a complete inventory of medical equipment throughout the ANA, and subsequent incorporation into the appropriate Tashkil, was to be completed in 2012. The initial milestone for this effort was February 2012, however, due to performance problems with the contractor responsible for conducting the inventory, the contract was terminated and a new contract was not yet in place.

[28] A pulse oximeter is used to measure the oxygen saturation level of the blood.

ISAF extended the milestones for the completion of the medical equipment inventory to October 31, 2012. As discussed previously, Observation 5 describes deficiencies identified in the ANA medical equipment maintenance and repair program, and includes additional detail on the problems noted with the contractor.

Although, the contractor made an attempt to perform an inventory of medical equipment at the NMH in 2011, the inventory documents were found to be incomplete. Specifically, 33 of 1046 medical equipment items were not properly allocated to a particular floor or department. Additionally, 18 of the 20 patient monitors and 10 vital signs machines mentioned previously could not be located on the inventory documents. This left an unclear picture as to the listing and quantity of medical equipment in each clinical area. Therefore, NMH leadership was not aware of medical equipment quantity and availability.

Lack of Policy to Support the Cross-Leveling of Essential Equipment

The NMH did not have an established policy or procedure that supported and encouraged the sharing of medical equipment between patient care areas. Cross-leveling equipment from an area of lower demand or patient acuity to an area with a higher patient census or patient demand would improve the efficiency of the medical equipment program. It would also ensure that the nursing staff who needed a particular piece of medical equipment for patient care would have it available for their use.

Figure 22. DoD IG Analyst Examining Patient Treatment Room

Source: DoD IG SPO

Increased Cooperation Among ANSF Medical Leadership

ANSF medical leaders, including the ANA and ANP Surgeon Generals were cooperating with each other to build an effective healthcare system. Specifically, during the July 2012 ANSF Healthcare Shura there was consensus among participating medical leaders to adjust current ANSF Tashkils by more evenly distributing functional on-hand equipment, follow through on repairing broken medical equipment, and improve ANSF medical logistics distribution, storage and accountability.

In summary, the incomplete medical equipment inventory and current Tashkil limited NMH leadership from effectively managing the scarce medical equipment resources within the hospital. Additionally, the absence of a command policy which allows for the cross-leveling of medical equipment hindered the provision of quality patient care. Improved use of medical equipment will result when procedures are implemented that support reallocation of underutilized equipment resources between patient care areas.

Recommendations:

6.a. NTM-A/CSTC-A, in coordination with MEDCOM, ensure that a medical equipment inventory is completed throughout ANA medical treatment facilities, including the NMH, and that medical equipment requirements are validated and included on the Tashkil.

6.b. NTM-A/CSTC-A, in coordination with MEDCOM and NMH, ensure that a process is established to cross-level medical equipment to ensure that the available equipment is properly utilized where needed.

Management Comments

NTM-A/CSTC-A concurred with comment to Recommendations 6.a and 6.b noting that medical equipment inventories were being completed by student biomedical equipment technicians during their practical training. However, these students were away undergoing officer training and would complete the inventories after their return in February 2013. Additionally, once the inventories were completed, the results would be compared to the Tashkil and excess medical equipment returned to the National Supply Depot for redistribution to facilities needing the item.

Our Response

NTM-A/CSTC-A's comments to Recommendations 6.a were partially responsive. We request that NTM-A/CSTC-A provide an update on the status of completion of ANA medical equipment inventories. Additionally, provide a copy of the completed inventories as well as the updated ANA Tashkil, which includes a listing of medical equipment and the department where the equipment is located.

NTM-A/CSTC-A's comments to Recommendation 6.b were partially responsive. We request that NTM-A/CSTC-A provide an update on the cross-leveling of medical equipment once the medical equipment inventories are completed. Additionally, in our report we identified that NMH did not have a policy addressing the cross-leveling of equipment. We request that NTM-A/CSTC-A, in coordination with MEDCOM and NMH, ensure that a process is established to cross-level medical equipment to ensure that the available equipment is properly utilized at the NMH where and when needed.

Observation 7. Availability of Disinfectants

Disinfectants and other cleaning supplies[29] necessary to properly sanitize hospital facilities and appropriate patient care areas were not consistently available at the National Military Hospital (NMH).

This was due, in part, to reliance on donations from contributing nations to provide disinfectants and cleaning supplies that were not always sufficient or timely. Additionally, the ANA did not properly establish a logistical means to procure the necessary disinfectants and cleaning supplies as a long-term solution.

As a result, the NMH did not always have the necessary supplies to ensure that all patient care areas were properly cleaned and disinfected. Consequently, patients, hospital staff and visitors were at risk for developing a nosocomial infection[30] which could adversely impact their health.

Applicable Criteria

MoD Decree 4.0 "Supported and Supporting Unit Logistics Policy and Support Procedures," January 2009. This document is the basic MoD policy guidance for ANA logistics doctrine and guidance.

NTM-A/CSTC-A "Standards for ANA Hospitals." This document provides a listing of standards and criteria for 22 departments or sections that was developed for ANA hospitals. The criteria are varied and labeled as Tier One, Tier Two and Tier Three, based on increasing levels of complexity.

NTM-A/CSTC-A "Validation Standards for ANSF Hospitals." It provides a rating tool that measures standards and criteria used to evaluate departmental performance according to Tier One of the ANSF Healthcare Standards. The standards identified for "Infection Control" are applicable to this observation and include criteria for hand washing and the cleaning and disinfection of patient treatment areas, medical equipment and other areas of the hospital. Additional standards apply to "Medical Logistics" that specify that the hospital has a supply requirement list approved by senior leadership which meets the needs across the ANSF healthcare system.

Discussion

We noted improvement in the overall appearance and cleanliness of the NMH since 2010. Recent changes made by the Chief of Hospital Administration resulted in an increase in the number of housekeepers available to clean the hospital. During our visit in July 2012 we observed multiple workers mopping the floors, cleaning bathrooms, and making an effort to minimize clutter and maintain an orderly appearance in patient care wards and other areas such as the pharmacy and medical logistics warehouse.

However, we found that disinfectants and other cleaning supplies necessary to properly sanitize the hospital were not always consistently and reliably available. In February 2012, we noted that

[29] Cleaning supplies include general soaps and anti-bacterial disinfectants.
[30] A nosocomial infection is an infection that develops in a hospital setting.

housekeepers were using plain water to mop the floors due to the lack of Dettol, a disinfectant solution, or other appropriate cleaning solutions. This was particularly challenging due to the snow, sand, and dirt from the outside that individuals tracked onto the floors of the hospital. This deficiency was addressed by leadership as adequate quantities of Dettol, Max (similar to a powdered household and industrial cleaner) and other cleaning supplies were present and in use during our July 2012 visit.

Weaknesses in the ANA Logistics System

The ANA relied on contributions from donor countries to provide disinfectants and other cleaning supplies for ANA hospitals and clinics, training centers, and dining facilities. These cleaning supplies are defined as Class II[31] supplies and therefore are managed by the ANA support staff without influence by MEDCOM.

ANA did not take appropriate action to establish a demand history and the requirements necessary for the procurement of the required cleaning supplies when advised by NTM-A to do so. Consequently, the last regular purchase of disinfectants and cleaning supplies using a CSTC-A Blanket Purchase Agreement was delivered to the NMH on November 27, 2011. Additionally, the lack of an established process to procure these supplies resulted in the ANA initiating three separate emergency purchases to ensure that disinfectants were available for hospitals, training centers and dining facilities. The last of these emergency purchases arrived in late May 2012 and was confirmed to be available at NMH in June 2012.

Working Towards a Solution to Improve the Reliable Availability of Disinfectants

In May 2012 the ANA MEDCOM Commander recognized that the logistical system in place at that time was insufficient to provide a reliable means of obtaining cleaning supplies required to properly sanitize ANA hospitals and clinics. He began working with NTM-A/CSTC-A and the ANA to establish a long-term solution to improve the reliability and availability of disinfectants and cleaning supplies. One strategy involved identifying specific cleaning supplies such as bleach, anti-bacterial soap, liquid hand soap, and waterless hand sanitizer as Class VIII[32] supplies which would be closely managed by MEDCOM.

The MEDCOM Commander and NTM-A advisors indicated that the lack of established procedures for ordering Class II cleaning supplies was not isolated to medical facilities. Other ANA activities such as dining facilities and training centers also had challenges ordering large amounts of disinfectants and cleaning supplies.

Improvements Needed in NTM-A Validation Tool

The NMH did not always have disinfectants available to properly ensure the effective cleaning of patient care areas. However, NTM-A/CSTC-A and MoD had not identified this critical issue during their inspections.

[31] Class II supplies are clothing, individual equipment, tools, tool kits, tents, administrative and housekeeping type supplies.
[32] Class VIII supplies are medical supplies, including repair parts for medical equipment.

The Validation Tool used to assess the performance of ANA hospitals had a defined standard for infection control which addressed hand washing and the cleaning and disinfection of patient treatment areas, medical equipment, and other areas of the hospital. However the criteria used to measure this standard lacked sufficient detail regarding the consistent and proper sanitation of hospitals. The availability and proper use of disinfectants was a critical factor in determining whether a hospital consistently met the criteria defined by these standards. See Part I: Notable Progress, "ANSF Healthcare Standards and Validation Tool" and Appendix E for a detailed description of the ANSF Healthcare Standards and the Validation Tool.

In summary, the sanitary conditions at the NMH had improved since 2010. However, the lack of an effective logistics system adversely affected the reliable availability of disinfectants and other cleaning supplies that were required to properly sanitize the hospitals and other communal establishments such as ANA dining facilities and training sites where multiple individuals reside. Consequently, the unavailability of these disinfectants may have jeopardized the health and well-being of patients, medical staff and ANA soldiers throughout Afghanistan.

Additional Progress

Both ANA MEDCOM and NMH leadership recognized the importance of using disinfectants to properly sanitize all areas of the hospital and were actively engaged with NTM-A and MoD entities to ensure that adequate cleaning supplies were properly planned for, procured and made available. Following our visit in July 2012, an NTM-A advisor informed the team that MEDCOM was successful in adding specific disinfectants and cleaning supplies, such as Dettol, bleach, hand sanitizer and hand-soap to the Class VIII Authorized Stock List (ASL) and implemented a procurement process to ensure that appropriate disinfectants and other cleaning supplies were available when needed. Additionally, appropriate ANA support staff developed and submitted a requirements list for the Class II cleaning supplies. This action was a key step and is necessary to ensure the reliable availability of appropriate disinfectants and other cleaning supplies throughout the ANA.

Recommendations

7.a. NTM-A/CSTC-A, in coordination with ANA GSG4, MoD Acquisition Technology and Logistics (AT&L) and LOGCOM, ensure that procedures are established for the procurement, delivery and reliable availability of janitorial cleaning supplies, which includes disinfectants.

7.b. NTM-A/CSTC-A, in coordination with MEDCOM, ensure that the Class VIII Authorized Stockage List is modified to include disinfectants and cleaning supplies. Additionally, ensure that these items are included in the 1392 and future Tashkils.

7.c. NTM-A, in coordination with MEDCOM, ensure that the ANSF Healthcare Standards and the NTM-A/CSTC-A Validation Tool include criteria which are specific to the availability and use of disinfectants to properly clean and sanitize ANA healthcare facilities.

Management Comments

NTM-A/CSTC-A concurred with Recommendations 7.a, 7.b, and 7.c and noted that required actions were completed. Specifically, per Recommendation 7.a, the non-medical quartermaster

for Class II cleaning supplies created a requirements list for the appropriate cleaning supplies and submitted them to the ANA GSG4 who was responsible for the procurement of the necessary supplies. Additionally, in response to Recommendation 7.b, bleach, Dettol, hand sanitizer, and hand soap were added to the Class VIII 1391 Authorized Stockage List and medical units submitted their 1392 requirements to MEDCOM G4 at the beginning of December 2012. Furthermore, in response to Recommendation 7.c, cleaning and sanitizing protocols as well as infection control, waste management training, and cleaning schedules for Housekeeping staff were incorporated into the Validation Tool for Housekeeping.

Our Response

NTM-A/CSTC-A's comments to Recommendations 7.a, 7.b, and 7.c were responsive. Request that NTM-A/CSTC-A provide a copy of the NTM-A Validation Tool for Housekeeping which identifies criteria for the cleaning and sanitizing protocols and infection control, waste management training, and cleaning schedules for housekeeping staff. Additionally, we request that NTM-A/CSTC-A provide an update on the procurement, delivery, and reliable availability of janitorial cleaning supplies, including disinfectants, in six months.

Appendix A. Scope, Methodology, and Acronyms

We conducted this assessment from May 2012 to September 2012, in accordance with the *Quality Standards for Inspections.* We planned and performed the assessment to obtain sufficient and appropriate evidence to provide a reasonable basis for our observations, conclusions, and recommendations, based on our objectives. Site visits to Afghanistan were conducted from June 26, 2012 to July 6, 2012.

We reviewed documents such as Federal Laws and regulations, including the National Defense Authorization Act, the Foreign Assistance Act, the Security Assistance manual, and appropriate CENTCOM, ISAF, USFOR-A, and CSTC-A guidance. Additionally, we reviewed U.S./NATO, ISAF, NTM-A/CSTC-A plans, orders, and other guidance associated with the efforts to develop health care capacity and capability within the NMH, to include reviewing of the published reports, operational plans and previous inspection and/or assessment reports related to the ANSF healthcare system and ANSF medical logistics

The scope of our assessment in Afghanistan was to continue oversight of U.S. and Coalition efforts to improve sanitary conditions and treatment of patients at the Dawood National Military Hospital (NMH) in Kabul Afghanistan, as well as monitor the development of a sustainable medical logistics and healthcare capability within the NMH. Specifically, we assessed progress made since previous DoD IG visits and reviewed the status of U.S. and Coalition efforts to:

- improve the healthcare management, staff attendance and treatment of patients at NMH
- remedy poor sanitation conditions
- improve medical logistics and pharmacy processes
- maintain effective force protection measures for the NTM-A Medical Embedded Training Team (METT)
- address corrupt activities within the NMH and actions to investigate past allegations

We met with U.S. Military and Coalition members from the NTM-A METT who mentor and advise at the NMH. We also interviewed NMH executive leaders and other NMH personnel to determine matters pertinent to the accountability of the medical staff and the ability of patients to receive prescribed medications and have access to the necessary durable medical equipment to promote their recovery.

Additionally, we conducted a walk-through of NMH focusing on assessing sanitary conditions of the hospital as well as the general overall physical condition of the patients. Our visit included wards where ANA patients were located and the ICU, and other areas including the Pharmacy and medical supply areas. During our visit to the patient care areas we interviewed 15 patients and their families. These interviews were structured around the criteria described in the "ANA Patient Bill of Rights" and pertained to the following: visits by their physician and nurse, frequency of dressing changes, availability of medications including pain medications, quality of the food, and cleanliness of the patient care areas.

We also interviewed NTM-A's Healthcare Validation Team to determine NMH's progress in meeting the established ANA Healthcare Standards.

Furthermore, we met with personnel associated with TF Shafafiyat and received an update on the Task Force's investigative efforts into allegations of fraud and corruption at NMH.

The NMH Team chronology was:

May – June 2012	Research and fieldwork in CONUS
June 26, 2012 to July 6, 2012	Fieldwork in Afghanistan
July 5, 2012	Outbrief to ISAF, IJC and NTM-A/CSTC-A
July – November 2012	Analysis and report writing
December 2012	Draft assessment report issued
January 2013	Management comments received and evaluated
March 2013	Report published

Limitations

We limited our review to DoD-funded programs, NATO-funded programs, and international donation programs supporting the security forces of Afghanistan.

Use of Computer-Processed Data

We did not utilize any computer-processed data in this assessment.

Use of Technical Assistance

We did not use technical assistance to perform this assessment.

Acronyms Used in this Report

The following is a list of the acronyms used in this report.

AFAMS	Armed Forces Academy of Medical Sciences
ANA	Afghan National Army
ANAREC	Afghan National Army Recruiting Command
ANP	Afghan National Police
ANSF	Afghan National Security Forces
ASFF	Afghanistan Security Forces Fund
ASL	Authorized Stockage List
AT&L	Acquisition Technology and Logistics
BMET	Bio-Medical Equipment Technician
CF	Coalition Forces

CJMED	Combined Joint Medical Branch
CJSURG	Combined Joint Surgeon
CM	Capability Milestone (a readiness level)
CSTC-A	Combined Security Transition Command-Afghanistan
CSSD	Central Sterile Supply Department
CT	Computed Tomography Scan
DoD	Department of Defense
DoDI	Department of Defense Instruction
DoD IG	Department of Defense Inspector General
DoD OIG	Department of Defense Office of the Inspector General
ENT	Ear, Nose, and Throat
GIRoA	Government of the Islamic Republic of Afghanistan
GS	General Staff
ICU	Intensive Care Unit
IJC	ISAF Joint Command
ISAF	International Security Assistance Forces
IV	Intravenous
LOGCOM	Logistics Command
LOE	Lines of Effort
MEDCOM	Medical Command
MEDLOG	Medical Logistics
METT	Medical Embedded Training Team
MoD	Ministry of Defense (Afghanistan)
MoI	Ministry of Interior (Afghanistan)
MoPH	Ministry of Public Health (Afghanistan)
MRI	Magnetic Resonance Imaging
MTAG	Medical Training Advisory Group
NATO	North Atlantic Treaty Organization
NDS	National Directorate of Security
NGO	Non-Governmental Organization
NMH	National Military Hospital
NTM-A	NATO Training Mission-Afghanistan
OEM	Original Equipment Manufacturer
OTSG	Office of the Surgeon General
PACU	Post-anesthesia Care Units or Postoperative Care Unit
PMI	Preventive Maintenance Inspections
PWS	Performance Work Statement
R&D	Reconciliation and Distribution
SOP	Standard Operating Procedure
SPO	Special Plans and Operations
USC	United States Code
USCENTCOM	U.S. Central Command
USFOR-A	U.S. Forces-Afghanistan

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Appendix B. Summary of Prior Coverage

During the last four years, the DoD, the Government Accountability Office (GAO) and the Department of Defense Inspector General have issued a number of reports and testimony discussing the development, accountability and control of logistics and supplies for the ANSF.

Unrestricted DoD reports can be accessed over be Internet at
http://www.defense.gov/pubs
Unrestricted GAO reports can be accessed over the Internet at
http://www.gao.gov
Unrestricted DOD IG reports can be accessed over the Internet
http://www.dodig.mil/audit/reports

Some of the prior coverage we used in preparing this report has included:

Congressionally Initiated Reports

Report to Congress in accordance with the 2008 National Defense Authorization Act (Section 1230, Public Law 110-181), as amended, "Report on Progress toward Security and Stability in Afghanistan," April and December 2012.

Report to Congress in accordance with the 2008 National Defense Authorization Act (Section 1230, Public Law 110-181), as amended, "Report on Progress toward Security and Stability in Afghanistan," April and December 2011.

Report to Congress in accordance with the 2008 National Defense Authorization Act (Section 1230, Public Law 110-181), as amended, "Report on Progress toward Security and Stability in Afghanistan," April and November 2010.

Report to Congress in accordance with the 2008 National Defense Authorization Act (Section 1230, Public Law 110-181), as amended, "Report on Progress toward Security and Stability in Afghanistan," June and October 2009.

Report to Congress in accordance with the 2008 National Defense Authorization Act (Section 1230, Public Law 110-181), "Report on Progress toward Security and Stability in Afghanistan," June 2008 and January 2009.

Government Accountability Office

GAO-12-951T, "Long-standing Challenges May Affect Progress and Sustainment of Afghan National Security Forces," July 24, 2012.

GAO-10-842T, "Preliminary Observations on DOD's Progress and Challenges in DistributingSupplies and Equipment to Afghanistan," June 2010.

GAO-10-655R, "Strategic Framework for U.S. Efforts in Afghanistan," June 2010.

GAO-08-661, “Further Congressional Action May Be Needed to Ensure Completion of a Detailed Plan to Develop and Sustain Capable Afghan National Security Forces,” June 2008.

Department of Defense Inspector General

DOD IG Report No. 2012-083, “Additional Guidance and Training Needed to Improve Afghan National Army Pharmaceutical Distribution,” May 7, 2012.

DOD IG Report No. SPO-2011-007, “Assessment of U.S. and Coalition Efforts to Develop the Medical Sustainment Capability of the Afghan National Security Forces,” June 14, 2011.

DOD IG Report No. SPO-2012-028, “Assessment of U.S. Government and Coalition Efforts to Develop the Logistics Sustainment Capability of Afghan National Army.” December 9, 2011.

DOD IG Report No. SPO-2010-001, “Assessment of U.S. and Coalition Efforts to Develop the Medical Sustainment Capability of the Afghan National Security Forces,” March 31, 2010.

DOD IG Report No. SPO-2009-007, “Report on the Assessment of U.S. and Coalition Plans to Train, Equip, and Field the Afghan National Security Forces,” September 30, 2009.

DOD IG Report No. SPO-2009-001, “Assessment of Arms, Ammunition, and Explosives Control and Accountability; Security Assistance; and Sustainment for the Afghan National Security Forces,” October 24, 2008.

Appendix C. Summary of Previous DoD IG Work

The DoD IG has been engaged in providing ongoing oversight with respect to U.S. Military and Coalition efforts to develop the Afghan military health care system, including the NMH, since 2008. Specifically we conducted five assessments, two criminal investigations and one audit. A description of the major findings from each project is summarized below:

Initial Assessment

In April 2008, the DoD IG conducted its first assessment[33] of DoD efforts to develop the ANSF, which included the military health care system. We determined that the complexity of medical stabilization and reconstruction challenges in Afghanistan called for a robust U.S. interagency and international effort to assist deployed U.S. military medical personnel in developing and implementing a detailed, multi-year planning strategy. At that time, the U.S. Central Command, ISAF, and CSTC-A lacked the personnel and other resource capability and expertise to expedite development of the ANSF health care system.

The report specifically noted that many U.S. military medical mentoring teams were not fully staffed, particularly those assigned to work with the Afghan police, and the development of ANSF medical personnel was seriously hampered, moreover, by inadequate U.S. military mentor headquarters guidance, and pre-deployment and in-country training. Further, we determined that the ANA Logistics Command was unable to support crucial ANA medical logistics requirements at NMH, as well as at the ANA Regional Hospitals.

The report concluded that the lack of progress in developing an effective Afghan military health care and logistical system would require prolonged combat casualty care assistance of ANSF personnel by the U.S. and other ISAF partner countries, and would delay development of an independent ANSF medical capability.

Second Assessment

In March 2009, we conducted a follow-up assessment[34] regarding ANSF medical system development. We determined that CSTC-A lacked a clearly defined plan with an end state goal for the development of the ANSF health care system and that planning which had previously been conducted had not been fully coordinated with the Afghan Ministries of Defense and Interior, and incorporated into their planning and operations. As a result, U.S. Military and ANSF resources were not being jointly focused, prioritized and executed in support of the development of a clearly defined and sustainable ANSF health care system, delaying progress in its accomplishment.

[33] Assessment of Arms, Ammunition, and Explosives Control and Accountability; Security Assistance; and Sustainment for the Afghan National Security Forces," released October 24, 2008 (Report No. SPO-2009-001).

[34] Assessment of U.S. and Coalition Efforts to Develop the Medical Sustainment Capability of the Afghan National Security Forces," released March 31, 2010 (Report No. SPO-2010-001).

Third Assessment

In November 2010, at the request of the Commander, NATO Training Mission – Afghanistan (NTM-A)/ CSTC-A, a DoD IG team conducted an assessment[35] of the ANA medical logistics system, which included the NMH, and made recommendations for strengthening the accountability and control of medical supplies purchased by DoD and distributed to the ANA medical system, including the NMH.

Our assessment determined that NTM-A/CSTC-A and the ANA's Office of the Surgeon General did not have a coordinated plan to achieve a transition end state, and that accountability and controls over the receipt, storage, accountability and distribution of pharmaceuticals and other medical supplies were insufficient to prevent theft, misappropriation, unauthorized use, or improper distribution.

Furthermore, due to the lack of developed, implemented, and enforced Afghan health care standards and a related U.S./Coalition mentoring model, it was not possible to provide a properly resourced and focused medical mentoring capability. Consequently, development of a sustainable health care system was hampered. The mentoring effort was also significantly hindered in its progress by having only half of the authorized U.S. personnel which was insufficient to effectively carry out the mission to support the timely development of the ANSF medical system.

Fourth Assessment (Quick-Look #1)

In February 2011, responding to concerns identified in an inspection report issued by a joint team of the Inspectors General of the Afghan Ministry of Defense, and CSTC-A, a DoD IG team conducted a "quick-look" assessment of the current status of healthcare, personnel, sanitation, supply and inventory issues at the NMH.

The team found that certain management, medical care and logistical challenges were prevalent. The NMH was understaffed and lacked sufficient numbers of ANA physicians, nurses, administrators and other staff. Additionally, there were staffing quality and attendance problems. In addition, though the Afghan Ministry of Defense had signed an order directing the transfer of medical logistics, then under the ANA's Office of Surgeon General /Medical Command, to the separate ANA Logistics Command in order to gain better MoD management control, this had not yet occurred.

There also was evidence that medical logistics system delivery of medical supplies to the hospital's pharmacy, and from the pharmacy to the patients, was dysfunctional. Further, we found a number of orthopedic operating tables, valued at over $400,000 each, the use of which appeared to be beyond the functional capability of the ANSF medical staff and which were still in their original packing crates.

Moreover, ANSF health care standards had not been defined. Therefore, it had not been feasible for the U.S./Coalition to build an effectively focused medical mentoring model, one that closely

[35] "Assessment of the U.S. Department of Defense Efforts to Develop an Effective Medical Logistics System within the Afghan National Security Forces," released June 14, 2011 (Report No. 2011-007).

linked standards to the necessary supporting health care policy. Established medical standards and implementing policy were also necessary for the U.S. military and ANA to determine the resources required in order to accomplish development of the intended end-state transition capability of the ANA health care system.

DoD Inspector General Visit

In November 2011, the DoD Inspector General at that time visited Afghanistan and Kabul, at which time he conducted a walk-through of the NMH. He subsequently noted to the Commander, NTM-A/CSTC-A that although progress had been made at the NMH, there were still issues that needed to be addressed and that DoD IG intended to continue to maintain oversight of NMH.

Fifth Assessment (Quick-Look #2)

In February 2012, DOD IG conducted its second quick-look assessment at the hospital. This visit supported the DoD IG intent to continue oversight activities at the NMH.

The DoD IG team interviewed patients and staff and toured the NMH. We noted improvement in the sanitary conditions of the hospital as well in the delivery of health care to the patients. Areas that still needed improvement included the accountability of personnel and the availability of medications and medical supplies. Additionally, we were informed that progress was being made at addressing allegations of corruption at the NMH.

Furthermore, we were informed that *CURE International* had been contracted by NTM-A to develop tiered (three tiers) health standards for the ANSF based on "Warrior Care." We understand that these standards were developed in 2011 and were being circulated through the ANSF Medical Commands for consideration. NTM-A utilized these standards to develop an instrument to evaluate performance based on the Tier 1 level of the *CURE International* standards. This instrument was called the NTM-A Validation tool and was used by the NTM-A Validation team in early February to assess the NMH.

DoD IG Investigations

During the past two years, DoD IG has conducted two criminal investigations related to the ANSF military health care system. The first was initiated based on allegations that a DoD contractor was not fulfilling its contractual obligations to safeguard U.S. purchased pharmaceutical supplies provided to the Government of Afghanistan. The investigation determined that the contract did not require the contractor to maintain inventory control and accountability of pharmaceutical products after they were turned over to the Government of the Independent Republic of Afghanistan (GIRoA) and the ANA. After pharmaceutical or other items are transferred to GIRoA control, DoD IG does not have investigative jurisdiction.

The second DoD IG investigation was initiated based on an allegation that U.S. supplied pharmaceuticals had been stolen from the ANSF military health care system. Interviews of the complainant, contractor personnel, as well as current and former U.S. Military personnel stationed in Afghanistan, determined that any theft of U.S. furnished pharmaceuticals would have occurred subsequent to the Government of Afghanistan accepting delivery of the pharmaceuticals. All relevant information was turned over to the anti-corruption Task Force

Shafafiyat[36] within ISAF to be provided to the Afghan Minister of Defense and/or Justice and acted on, as appropriate.

DoD IG Audit

In response to the results of the February 2011 quick-look assessment, DoD IG conducted an audit[37] to determine whether the pharmaceutical distribution process within the ANA military health care system was sufficiently effective and secure.

The team found that although the ANA pharmaceutical distribution process had improved since the NMH inspection in February 2011, the delivery and inventory control processes for pharmaceuticals at medical facilities and depots required further work. Although Afghan Logistics Command officials did effectively receive, account for, and prepare pharmaceuticals for issuance to the forward supply depots and NMH, four of the six medical facilities reviewed either had no pharmaceutical accountability controls or did not maintain the controls they had. Specific to NMH, the audit team could not verify the accuracy of the inventory on hand because the dispensing documentation was not reconciled to the stock accounting record. Further, none of the six medical facilities reviewed properly used or completed required Afghan Ministry of Defense supply forms.

In addition, Afghan Medical Command officials, in coordination with CSTC-A, had not developed procedures instructing medical facility personnel how to implement logistics guidance, and to collect and accurately report on pharmaceutical usage data. As a result, the ANA could not rely upon this data to develop sound pharmaceutical supply requirements, and there was an unacceptable risk of mismanagement, theft, and waste of U.S. funded pharmaceuticals.

[36] Task Force Shafafiyat's mission is to plan and implement ISAF anti-corruption efforts, and integrate intelligence with planning, operations, engagement, and strategic communications. It integrates U.S. anticorruption activities with key partners in the international community and the Government of Afghanistan.

[37] "Additional Guidance and Training Needed to Improve Afghan National Army Pharmaceutical Distribution," released May 7, 2012 (Report No. DODIG-2012-083).

Appendix D. Criteria

U.S. Department Of Defense

Department of Defense 6010.13 - Manual "Medical Expense and Performance Reporting System for Fixed Military Medical and Dental Treatment Facilities Manual," April 7, 2008. The manual, among other things, defines biomedical equipment repair as a function which provides preventive maintenance, inspection, and repair of medical and dental equipment. Specific responsibilities include the following: conducts a systematic inspection of equipment to determine operational status, and assigns serviceability condition codes to equipment; performs scheduled preventive maintenance of medical and dental equipment; repairs or replaces worn or broken parts; rebuilds and fabricates equipment or components; and modifies equipment and installs new equipment.

International Security Assistance Force (ISAF)

ISAF "Afghan National Security Forces (ANSF) Healthcare System Development Support Plan to COMISAF OPLAN 38302," dated November 28, 2011. This transition plan was developed to guide Coalition efforts in their assistance to the ANSF in the development of their healthcare system. The transition objective for the ANSF is focused on Warrior Care and provides health support to the ANSF member from recruitment through to discharge in both outpatient and inpatient settings. Specifically, this plan identifies the focus areas, transition objectives and lines of operation for the ANSF and Coalition as they work towards transition to Afghan-lead.

Standard Operating Procedure HQ-01149, "ISAF / Coalition Medical Rules of Eligibility," dated December 15, 2011. This procedure outlines and establishes the principles of eligibility and entitlement to ISAF and Coalition Force medical care and transportation provisions for patients and casualties within the Combined Joint Operational Area.

North Atlantic Treaty Organization (NATO) Training Mission – Afghanistan (NTM-A)/Combined Security Transition Command – Afghanistan (CSTC-A), "Standards for ANA Hospitals." Healthcare standards developed in support of establishing a minimal standard for the operations of the ANSF healthcare system. These standards and criteria were developed for 25 departments and/or sections pertinent to ANSF hospital operations. The criteria is varied and labeled as Tier One, Tier Two and Tier Three, based on increasing levels of complexity of the criteria and standards. These standards are commonly referred to as the ANSF Healthcare Standards.

NTM-A/CSTC-A, "Validation Standards for ANSF Hospitals." A rating tool which provides the standard and criteria used to evaluate a departments performance according to Tier One of the ANSF Healthcare Standards.

Afghanistan Ministry of Defense (MoD)/Afghan National Army (ANA)/ANA Medical Command

MoD Decree 4.0 "Supported and Supporting Unit Logistics Policy and Support Procedures," January 2009. This decree describes common procedures, formats, and forms for the communication of logistic information between supported activities and the supply and materiel management of the MoD.

Afghan National Army (ANA) – Approved Tashkil - 1391 National Military Hospital – Equipment. This document is the approved ANA equipment authorization for the NMH for the solar year 1391, which was current during the time of our visit. The document includes a listing of equipment by type, item name and quantity relevant to individual departments at the NMH

Afghan National Army – Approved Tashkil - 1391 National Military Hospital – Personnel. This document is the approved ANA personnel authorization for the NMH for the solar year 1391, which was current during the time of our visit. The document includes a listing of authorized staff positions detailed by paragraph/line numbers, rank, military occupational skill, additional skill identifier(s), position and required strength, by department at NMH.

MEDCOM "Policy Regarding Control of Medications," dated August 5, 2012, (Solar Year 15-5-1391)." This Afghan policy provides guidance pertinent to accountability and control measures in ANA pharmacies which prevent waste and misuse of medications. Specifically, this policy addresses the stocking and control of medications; distribution of medications to eligible patients; and required accountability reports.

ANA National Military Hospital, Kabul "Policies and Procedures of the Pharmacy Department" Revised 2012 (Solar Year 1391). This manual describes the policies and procedures pertinent to the pharmacy at NMH including job responsibilities for pharmacy personnel, procedures for the security and storage of pharmaceuticals and guidelines for the management and dispensing of medications.

Appendix E. Afghan National Security Forces (ANSF) Healthcare Standards and Development of Validation Tool

Development of ANSF Healthcare Standards

CURE International was contracted by NTM-A/CSTC-A in March 2010 to develop tiered healthcare standards based on Warrior Care[38] for the ANSF. *CURE International's* final product, "ANSF Healthcare Standards" was delivered in April 2012 and was designed to improve the healthcare system to a level of quality or excellence that is accepted as the norm or by which actual attainments are judged. Additionally, as part of the contract, *CURE International* provided training to ANSF medical personnel on how to use and grade the standards.

Each of the following areas represented the specific standards that were developed by CURE:

- Anesthesia
- Biomedical Engineering
- Blood Banking
- Central Sterilization and Supply Department
- Emergency Room
- Facilities
- Hospital Leadership Council
- Human Resources
- Infection Prevention
- Intensive Care Unit
- Internal Medicine
- Laboratory
- Medical Logistics
- Nursing
- Obstetrics
- Operating Theater
- Outpatient Department
- Patient Administration
- Pediatrics
- Pharmacy
- Radiology
- Surgery

Additionally, *CURE International* used a "tiered" approach in developing the ANSF Healthcare Standards, whereby successive "tiers" represented a graduated measurement of capabilities based on defined standards and criteria. Specifically, Tier 1 standards demonstrated functions of a basic, self-sustaining healthcare system; Tier 2, a self-sustaining healthcare system with limited advance capabilities; and Tier 3 standards represented advanced capabilities and included criteria for credentialing and advanced certifications.

Furthermore, the ANSF Healthcare Standards provide a guideline to help focus NTM-A advisory and mentoring efforts.

NTM-A Validation Tool

NTM-A used the standards produced by *CURE International* as the foundation to develop a comprehensive tool and relevant specific criteria to assess each standard at the Tier 1 level. Given that the ANSF Healthcare Standards were intended to be based on Warrior Care, NTM-A

[38] ISAF defines 'Warrior Care' as caring for the ANSF member from recruitment throughout his time in the ANSF which includes care aimed at the prevention of ill health, and treatment of any illness or injury while serving.

excluded Obstetrics and Pediatrics Standards developed by *CURE International* and included Dental and Physical Therapy when they developed their assessment tool.

The Validation Tool was used by NTM-A to assess each ANSF hospital beginning in December 2011. Each hospital department or specific functional area was scored based on the level of compliance in attaining the relevant criteria. Specifically, the following scoring methodology was used: Score of 0 (no evidence of compliance); Score of 1 (evidence of compliance, however they were inconsistent in performance) and; Score of 2 (evidence of consistent compliance).

Validation Tool Used to Determine Capability Milestone (CM) Ratings

The scores derived from the Validation Tool were used to determine the level of compliance by individual departments. These scores were compiled into a metric that was used to determine a CM rating for each area assessed, as well as an overall CM rating for the hospital. The CM rating identified the level of current capabilities that served as a forecast to when the hospital will most likely be ready to transition to Afghan-lead.

There are six milestones ranging from CM-4 through CM-1A. Specifically the ratings are defined as follows:

- CM-4 indicates the institution cannot accomplish its mission.
- CM-3 indicates the institution cannot accomplish its mission without significant coalition assistance.
- CM-2B indicates the institution can accomplish its mission with some coalition assistance.
- CM-2A indicates the institution is capable of executing functions with minimal coalition assistance.
- CM-1B indicates the institution is capable of executing functions with coalition oversight only.
- CM-1A indicates the institution is capable of autonomous operations with reduced coalition oversight.

Validation Team Assessments

NTM-A intends to conduct quarterly assessments of all ANA hospitals using the Validation Tool to determine CM ratings. The goal for transition is to achieve a CM-1B rating for the Tier 1 Healthcare Standards. The initial round of inspections began in December 2011 and ended in February 2012.

The second round of inspections began in May and ended in September 2012. NTM-A's Validation team worked side-by-side with the ANA's Validation Team from MEDCOM's Quality Improvement, Standards, and Metrics Division during this second round of inspections. See Table 9 and 10 for a summary of the last two inspections.

Future assessments will continue on a quarterly basis by the NTM-A Validation Team, and semi-annually by MEDCOM's Validation team.

Additionally, the results of the Validation Team's assessments help to guide and prioritize NTM-A's advisory efforts. Specifically, they will focus their mentoring efforts on those departments who have yet to achieve a CM-1B rating.

Table 9. NTM-A Validation Tool and Associated Capability Milestones (CM) Ratings for ANA and ANP Hospitals for December 2011-February 2012

Departments	ANPH	NMH	Herat	Kandahar	Mazar-e Sharif	Paktiya
Anesthesia	CM2B	CM-2B	CM-2B	CM-2A	CM-2B	CM-1B
Bio-Medical Repair	CM4	CM-2B	CM-4	CM-4	CM-2B	CM-4
Blood Bank	CM2A	CM-1B	CM-2A	CM-2A	CM-2B	CM-2A
CSSD	CM3	CM-2B	CM2B	CM-3	CM-2B	CM-2A
Dental	CM4	CM-1B	CM-3	CM-3	CM-1B	CM-2A
Emergency	CM3	CM-2B	CM-2B	CM-3	CM-2A	CM-2A
Facilities Management	CM3	CM-2B	CM-2B	CM-2B	CM-2B	CM-2B
Human Resources	CM2B	CM-1B	CM-1B	CM-3	CM-2A	CM-2B
ICU	N/A	CM-2A	CM-3	CM-3	CM-2B	CM-2A
Infection Prevention	CM3	CM-3	CM-3	CM-2B	CM-3	CM-1B
Internal Medicine	CM2B	CM-2A	CM-2B	CM-2B	CM-2B	CM-2A
Laboratory	CM1B	CM-2A	CM-2A	CM-2B	CM-2A	CM-2B
Leadership Council	CM2B	CM-1B	CM-2B	CM-2B	CM-1B	CM-1B
MEDLOG	N/A	CM-1B	CM-4	CM-3	CM-2B	CM-2A
Nursing	CM2B	CM-2B	CM-2B	CM-2A	CM-2B	CM-2A
Operating Theater	CM3	CM-3	CM-3	CM-2B	CM-2B	CM-1B
Outpatient	CM2B	CM-2A	CM-3	CM-3	CM-2B	CM-2A
Patient Administration	CM2A	CM-1B	CM-2A	CM-2A	CM-1B	CM-1B
Pharmacy	CM3	CM-2A	CM-2B	CM-2A	CM-1B	CM-2B
Pharmacy Clinic	CM3	CM-2A	N/A	N/A	N/A	N/A
Physical Therapy	N/A	CM-1B	CM-3	CM-3	CM-2A	CM-2B
Preventative Medicine	CM2B	CM-2A	CM-2B	CM-2B	CM-2A	CM-1B
Radiology, Ultrasound, CT, MRI	CM3	CM-3	CM-2B	CM-2B	CM-2B	CM-2A
Surgery	CM2B	CM-1B	CM-2B	CM-2B	CM-2B	CM-2B
Polyclinic Laboratory	N/A	CM-2A	N/A	N/A	N/A	N/A
Polyclinic Radiology	N/A	CM-3	N/A	N/A	N/A	N/A
OVERALL RATING	CM3	CM-2A	CM-2B	CM-2B	CM-2B	CM-2A

Color-Coding is based on the level of CM rating with red as the lowest level of CM-4; Orange as CM-3; Yellow as CM-2B; and variations of green for CM-2A, CM-1B and CM-1A. CM1B is the goal to determine the readiness towards transition

Source: NTM-A

Table 10. NTM-A Validation Tool and Associated Capability Milestones (CM) Ratings for ANP and ANA Hospitals for June 2012 – October 2012

Departments	ANPH	NMH	Herat	Kandahar	Mazar-e Sharif	Paktiya
Anesthesia	CM-1B	CM-2A	CM-1B	CM-1A	CM-1B	CM-1B
Bio-Medical Repair	CM-2B	CM-1B	CM-1A	CM-4	CM-2B	CM-4
Blood Bank	CM-1B	CM-1A	CM-1A	CM-1B	CM-1B	CM-1A
CSSD	CM-2A	CM-1A	CM-1B	CM-1B	CM-1A	CM-1A
Dental	CM-1B	CM-1A	CM-1A	CM-2A	CM-1A	CM-1A
Emergency	CM-2A	CM-2A	CM-1B	CM-1B	CM-1B	CM-1B
Facilities Management	CM-3	CM-1B	CM-1A	CM-1B	CM-1B	CM-1B
Human Resources	CM-2A	CM-1A	CM-1A	CM-1A	CM-1A	CM-1A
ICU	NA	CM-1A	CM-1A	CM-1B	CM-1A	CM-1A
Infection Prevention	CM-2B	CM-1B	CM-2B	CM-2B	CM-1A	CM-1A
Internal Medicine	CM-1A	CM-1A	CM-1A	CM-2A	CM-1A	CM-1A
Laboratory	CM-1B	CM-1A	CM-1A	CM-1A	CM-1A	CM-1A
Leadership Council	CM-1A	CM-1A	CM-1A	CM-1B	CM-1A	CM-1A
MEDLOG	CM-1B	CM-1A	CM-1A	CM-1A	CM-1A	CM-1A
Nursing	CM-1B	CM-1A	CM-1B	CM-1A	CM-1A	CM-1A
Operating Theater	CM-2A	CM-1A	CM-1B	CM-2A	CM-1A	CM-1A
Outpatient	CM-1A	CM-1A	CM-1A	CM-1A	CM-1B	NA
Patient Administration	CM-1B	CM-1A	CM-1A	CM-1A	CM-1A	CM-1A
Pharmacy	CM-2A	CM-1A	CM-1A	CM-1A	CM-1A	CM-1A
Pharmacy Clinic	NA	NA	NA	NA	NA	NA
Physical Therapy	CM-2A	CM-2A	CM-1A	CM-1A	CM-1B	CM-2B
Preventative Medicine	CM-1B	CM-2A	CM-2A	CM-2A	CM-1B	CM-1A
Radiology	CM-1B	CM-1B	CM-2A	CM-1A	CM-1B	CM-1A
Ultrasound	NA	CM-1B	CM-2B	CM-1B	CM-1A	CM-1A
MRI	NA	CM-2A	NA	NA	NA	NA
CT	NA	CM-2A	NA	NA	NA	NA
Surgery	CM-1B	CM-1A	CM-1A	CM-1A	CM-1B	CM-1B
OVERALL	CM-2A	CM-1B	CM-1B	CM-1B	CM-1B	CM-1B

Color-Coding is based on the level of CM rating with red as the lowest level of CM-4; Orange as CM-3; Yellow as CM-2B; and variations of green for CM-2A, CM-1B and CM-1A. CM1B is the goal to determine the readiness towards transition

Source: NTM-A

Appendix F. Afghan National Security Forces (ANSF) Healthcare System Development Support Plan to COMISAF OPLAN 38302

The ISAF with input from IJC, NTM-A/CSTC-A and United States Forces Afghanistan (USFOR-A) staff officers and medical planners, and discussed with ANSF leadership, developed and published a medical transition plan in November 2011. The vision driving the planning effort, and the ANSF Healthcare System development effort overall, was "quality warrior care, from point of injury through a professional, ethical, effective and efficient medical system, to recovery and discharge, for the nation's defenders."

Warrior Care, for the purposes of this plan, was care for the ANSF member from recruitment throughout his time in the ANSF. Additionally, the focus of the care provided was aimed both at prevention of ill health, and at treatment of any illness or injury while serving. Specifically the components involved in Warrior Care are the following:

- force health protection,
- primary care, that is, routine treatment of sickness and minor injuries,
- point of injury care and ground medical evacuation from the battlefield or other emergency situation,
- damage-control resuscitation,
- damage-control surgery, and
- secondary care in hospitals ,whether for illness or injury.

The focus areas of this plan and corresponding transition objectives were as follows:

Organization - "The organization of the ANSF medical system will be optimized in terms of core processes, sustainable tashkil, clear and reliable command and control, and capability laydown, thereby ensuring maximal efficiency of healthcare delivery."

Personnel - "Effective operation of an ANSF-developed, requirements-driven, personnel management system that continuously adapts to meet the changing needs of the Afghan healthcare system and results in optimal staffing, with appropriate geographic distribution."

Education and Training - "A standards-based, ethics driven system of education and training that produces professional and competent healthcare providers, administrators, and technicians that is responsive to enterprise requirements, adaptive to emerging demands, and sustainable."

Evacuation - "An efficient sustainable ANSF ground casualty evacuation capability, tailored to geographical region, with developing en route care capability."

Quality Management - "An enduring culture of quality will exist within the ANSF health systems, manifest by continuously improving metrics of clinical outcomes, independently fostered by ANSF quality management experts and programs. Ideally, the ANSF culture of

quality will spur the development of and be supported by a culture of quality within the broader health systems within Afghanistan, as reflected in national quality and credentialing standards."

Logistics - "A requirements-driven and accountable requisition, receipt, reconciliation and distribution medical logistics process, embedded within the MoD and MoI logistics and aligned to ANSF clinical needs.

Appendix G. ANA Patient Bill of Rights

ANA MEDCOM developed a set of standards which described activities and behaviors which patients can expect when they are hospitalized in an ANA hospital. These standards were referred to as the ANA Patient Bill of Rights and are posted in Dari in areas throughout the hospital

Figure 23. ANA Patient Bill of Rights

Source: NTM-A

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Appendix H. Management Comments

Commander, ISAF Comments

DODIG Draft Report – Dated 05 December 2012
(DODIG *Project No. D2012-D00SPO-0163.000*)

"Oversight of U. S. Military and Coalition Efforts to Improve Healthcare Conditions and to Develop Sustainable ANSF Medical Logistics at the Dawood National Military Hospital"

Commander, International Security Assistance Force

RECOMMENDATION 1a: ISAF, in coordination with IJC/NTM-A, MoD-Health Affairs and the ANA Surgeon General, develop and implement policy and procedures that guide the transfer of patients between Coalition and other GIRoA medical facilities. These policies should be applicable to the Coalition medical facility when they transfer a patient, and to a GIRoA medical facility who would receive the transferred patient. Additionally, these procedures include a determination that addresses the acuity of the patient, and ensures that suitable ANSF medical personnel and the appropriate medical equipment are available prior to the transfer of the patient.

RESPONSE: ISAF Concurs with the recommendation provided in this DODIG report.

Jeffrey L. Milhorn

APPROVED BY:
Jeffrey L. Milhorn
COL, USA
Assistant Chief of Staff, ISAF

Commander, IJC Comments

DODIG Draft Report – Dated 05 December 2012
(DODIG *Project No. D2012-D00SPO-0163.000*)

"Oversight of U. S. Military and Coalition Efforts to Improve Healthcare Conditions and to Develop Sustainable ANSF Medical Logistics at the Dawood National Military Hospital"

Commander, International Security Assistance Force Joint Command

RECOMMENDATION 1a: ISAF, in coordination with IJC/NTM-A, MoD-Health Affairs and the ANA Surgeon General, develop and implement policy and procedures that guide the transfer of patients between Coalition and other GIRoA medical facilities. These policies should be applicable to the Coalition medical facility when they transfer a patient, and to a GIRoA medical facility who would receive the transferred patient. Additionally, these procedures include a determination that addresses the acuity of the patient, and ensures that suitable ANSF medical personnel and the appropriate medical equipment are available prior to the transfer of the patient.

RESPONSE: Concurs with information provided in this DODIG report.

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APPROVED BY:
Lawrence Nixon
Col, USAF
Inspector General

PREPARED BY:
David Fugazzotto
LTC, USA
IJC CJ MED

NTM-A Comments

HEADQUARTERS
NATO TRAINING MISSION – AFGHANISTAN
COMBINED SECURITY TRANSITION COMMAND – AFGHANISTAN
KABUL, AFGHANISTAN
APO, AE 09356

REPLY TO ATTENTION OF

NTM-A/CSTC-A 1 January 2013

MEMORANDUM THRU United States Forces - Afghanistan (CJIG), APO AE 0935United States Central Command (CCIG), MacDill AFB, FL 33621

FOR Office of the Department of Defense – Inspector General, Special Plans and Operation 4800 Mark Center Drive, Alexandria, VA 22350-1500

SUBJECT: NTM-A/CSTC-A Response to the Draft Report "Oversight of U.S. Military and Coalition Efforts to Improve Healthcare Conditions and to Develop Sustainable ANSF Medical Logistics at the Dawood National Military Hospital" (D2012-D00SPO-0163.000)

REFERENCE: Draft Report, dated 5 Dec 2012, Department of Defense Inspector General

1. The purpose of this memorandum is to provide a response to recommendations 1.a, 2.a, 2.b, 3.a, 4.a, 4.b, 4.c, 5.a, 5.b, 5.c, 5.d, 6.a, 6.b, 7.a, 7.b, 7.c within the referenced DoD IG SPO Draft Report at Enclosure 1.

2. Point of contact for this action is [redacted]

1 Encl
As

ANDREW J. JORGENSEN
Col, USAF
Command Surgeon

DRAFT REPORT

"Assessment on Oversight of U.S. Military and Coalition Efforts to Improve Healthcare Conditions and to Develop Sustainable ANSF Medical Logistics at the Dawood National Military Hospital" (*D2012-D00SPO-0163.000*)

NTM-A/CSTC-A

GENERAL COMMENTS ON THE DRAFT REPORT

1. Recommendation 1.a, Page 28, states:
ISAF, in coordination with IJC/NTM-A, MoD-Health Affairs and the ANA Surgeon General, develop and implement policy and procedures that guide the transfer of patients between Coalition and other GIRoA medical facilities. These policies should be applicable to the Coalition medical facility when they transfer a patient, and to a GIRoA medical facility who would receive the transferred patient. Additionally, these procedures include a determination that addresses the acuity of the patient, and ensures that suitable ANSF medical personnel and the appropriate medical equipment are available prior to the transfer of the patient.

a. NTM-A/CSTC-A Response Comments to DoD IG SPO Draft Report Recommendation 1.a:

Provide NTM-A/CSTC-A response and/or requested information, to include any supporting documentation as necessary Concur. ISAF, in conjunction with MoD-HA, ANA SG, MoPH, ANP SG, Coalition medical facilities will continue to develop and refine policy and procedure guidelines as CASEVAC/Ground Evacuation procedures are validated.

2. Recommendation 2.a, Page 32, states:
NTM-A, in coordination with MEDCOM and NMH, ensure that policy is established to identify appropriate inventory control measures for each area where medications are stored including pharmacy storage rooms, dispensing areas and patient wards.

a. NTM-A/CSTC-A Response Comments to DoD IG SPO Draft Report Recommendation 2.a:

Provide NTM-A/CSTC-A response and/or requested information, to include any supporting documentation as necessary Concur. NTM-A/CSTC-A, working with MECOM and NMH has developed a proposed Pharmacy SOP that contains inventory control measures for medications stored in the Pharmacy Dispensing Room, Pharmacy Depot, Pharmacy Duty Room, and Hospital Wards. Practices defined in the SOP include the use of stock cards to maintain running tallies of shelf inventory, limiting personnel access, maintaining Ward logbooks, and specifying the periodicity of taking inventory.

3. Recommendation 2.b, Page 32, states:
NTM-A, in coordination with MEDCOM and NMH, ensure that policy guidance is established to clearly define the proper security measures for controlled substances, including the appropriate storage container and physical means to secure the container.

a. NTM-A/CSTC-A Response Comments to DoD IG SPO Draft Report Recommendation 2.b:

DRAFT REPORT
"Assessment on Oversight of U.S. Military and Coalition Efforts to Improve Healthcare Conditions and to Develop Sustainable ANSF Medical Logistics at the Dawood National Military Hospital" (*D2012-D00SPO-0163.000*)
NTM-A/CSTC-A
GENERAL COMMENTS ON THE DRAFT REPORT

Provide NTM-A/CSTC-A response and/or requested information, to include any supporting documentation as necessary. Concur – accomplished. Controlled substances are defined in the 1391 authorization list. The current policy clearly outlines inventory control through use of MoD forms, stock cards, and logs. The conduct of regular inventory verifications and unannounced inspections and security of controlled substances including personnel access and escort lists and locked depots, dispensing rooms, and cabinets are also addressed. More protective vaults and narcotic cabinets have been requested via NATO funding to better secure the controlled medications.

4. Recommendation 3.a, Page 37, states:
NTM-A, in coordination with MEDCOM and NMH, re-assess and validate the number of pharmacists and pharmacy personnel that are necessary to support the effective and efficient operation of the NMH pharmacy. Additionally, identify and implement interim measures to ensure that qualified personnel are available to meet the current workload demands in the NMH pharmacy.

a. NTM-A/CSTC-A Response Comments to DoD IG SPO Draft Report Recommendation 3.a:
Provide NTM-A/CSTC-A response and/or requested information, to include any supporting documentation as necessary. Concur with comment. Higher patient volume and pharmacy workload places increasing demands on NMH pharmacy staff. Insufficient pharmacists at NMH hinder pharmacy operations and have the potential to adversely affect the safety and health of patients receiving medical care at NMH. The proposed 1392 Tashkil shows an increase from five pharmacists to seven when combining Armed Forces Academy of Medical Science (AFAMS) pharmacy staff into functional personnel assets in both NMH and AFAMS. The addition of two pharmacists will alleviate some of the demands, but the NMH pharmacy, based on a comprehensive analysis of hospital operations, ultimately requires ten pharmacists to provide full pharmaceutical services including after hours coverage. This recommendation has been forwarded for consideration to MEDCOM. Pharmacists in the next graduating class from Kabul Medical University are slated to fill ANA positions. As well, there are processes available to recruit Pharmacists from the civilian sector.

5. Recommendation 4.a, Page 41, states:
NTM-A, in coordination with MEDCOM and NMH, ensure that policy is established to allow for the cross-leveling of nursing personnel based on workload demands within the NMH.

a. NTM-A/CSTC-A Response Comments to DoD IG SPO Draft Report Recommendation 4.a:

Provide NTM-A/CSTC-A response and/or requested information, to include any supporting documentation as necessary Concur. Currently, the NMH Chief of Nursing reports most departments are staffed well, ranging from 84.6%-150%. The improvement can be attributed to the Chief of Nursing in that his current policy and procedures allows for cross leveling nursing personnel to any specific ward or patient care area according to demand.

6. Recommendation 4.b, Page 41, states:
NTM-A, in coordination with MoD Health Affairs and MEDCOM, ensure that the Tashkil identifies the appropriate type and number of nurses required at NMH according to the MEDCOM nursing definitions. Additionally, ensure that current recruiting practices are reviewed and identify and implement measures to fill current nursing vacancies in the NMH Tashkil.

a. NTM-A/CSTC-A Response Comments to DoD IG SPO Draft Report Recommendation 4.b:

Provide NTM-A/CSTC-A response and/or requested information, to include any supporting documentation as necessary Concur – accomplished. According to NHM Chief of Nursing with concurrence from Coalition Senior Nurse Mentor, current overall percentage of authorized Tashkil 1391 is 86.63% of which the top seven departments by authorization are primarily over 100% filled (only three were at 86.6%,90%, and 93%). All nursing personnel have specific written job functions and descriptions. They undergo semi-annual and annual evaluations as well as verification of nursing credentials and certificates. The Chief of Nursing agrees that one of his main challenges is ensuring continuity in his nursing staff as nurses retire or resign. Current recruiting practices are being reviewed with MEDCOM to address these potential gaps in nursing personnel.

7. Recommendation 4.c, Page 41, states:
NTM-A, in coordination with MEDCOM, consider the addition of criteria to the Validation Tool which would allow for the MEDCOM inspectors to evaluate whether the NMH is able to shift nursing resources based on patient census and patient acuity.

a. NTM-A/CSTC-A Response Comments to DoD IG SPO Draft Report Recommendation 4.c:

Provide NTM-A/CSTC-A response and/or requested information, to include any supporting documentation as necessary Concur with comment. In post-transition assessments of the hospitals, MEDCOM will be moving away from a strict Validation Tool and utilizing survey methods to determine effectiveness of hospital practices and processes. The survey method will address adequacy of staffing in meeting nursing needs relative to patient census and morbidity.

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8. Recommendation 5.a, Page 48, states:
NTM-A/CSTC-A, in coordination with MEDCOM, develop a plan which ensures that NMH and other ANA hospitals have a viable medical equipment repair program.

a. NTM-A/CSTC-A Response Comments to DoD IG SPO Draft Report Recommendation 5.a:

Provide NTM-A/CSTC-A response and/or requested information, to include any supporting documentation as necessary Concur with comment. In order to sustain the ANA medical assets, coalition forces assisted in establishing a biomedical equipment repair training program through the ANA Armed Forces Academy of Medical Sciences with the first class of 20 biomedical equipment technicians (BMET) expected to graduate the first quarter of 2013. The biggest challenge here has been the lack of basic literacy and mathematics skills. Thus a program that was originally a year long, stretched to two years to include basic education and English language training (nearly all manuals for equipment are in English). Once training is complete in February 2013, this force of biomedical repair technicians will be deployed to the hospitals to provide basic biomedical repair.

9. Recommendation 5.b, Page 48, states:
NTM-A/CSTC-A expedite contracting efforts to ensure that there is executable medical equipment maintenance and repair capability throughout the ANA.

a. NTM-A/CSTC-A Response Comments to DoD IG SPO Draft Report Recommendation 5.b:

Provide NTM-A/CSTC-A response and/or requested information, to include any supporting documentation as necessary Concur. NTM-A and ANSF are actively engaged in establishing a medical equipment maintenance contract owned and managed by the ANA (assisted by NTM-A advisors) to maintain their medical assets. NTM-A Finance officer submitted the contract requirements to the ANA medical leadership on 23 December 2012, though challenges lie in finding a contractor with enough medical equipment technicians with the required skill sets.

10. Recommendation 5.c, Page 48, states:
NTM-A/CSTC-A, in coordination with MEDCOM, ensure that graduating BMET technicians are assigned to ANA hospitals based on priorities and needs of the current medical equipment repair programs.

a. NTM-A/CSTC-A Response Comments to DoD IG SPO Draft Report Recommendation 5.c:

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Provide NTM-A/CSTC-A response and/or requested information, to include any supporting documentation as necessary Concur with comment. Current plan is to equally distribute BMETs to four per each RMH. All RMHs should be equipped in essentially identical ways and face equivalent repair needs.

11. Recommendation 5.d, Page 48, states:
NTM-A/CSTC-A, in coordination with MEDCOM, ensure that medical gas containers and cylinders are properly secured to the floor or wall to prevent them from falling.

a. NTM-A/CSTC-A Response Comments to DoD IG SPO Draft Report Recommendation 5.d:

Provide NTM-A/CSTC-A response and/or requested information, to include any supporting documentation as necessary Concur. MEDCOM Validation Team inspects for compliance on proper securing of tanks/cylinders as part of their Validation Tool for Facilities.

12. Recommendation 6.a, Page 52, states:
NTM-A/CSTC-A, in coordination with MEDCOM, ensure that a medical equipment inventory is completed throughout ANA medical treatment facilities, including the NMH, and that medical equipment requirements are validated and included on the Tashkil.

a. NTM-A/CSTC-A Response Comments to DoD IG SPO Draft Report Recommendation 6.a:

Provide NTM-A/CSTC-A response and/or requested information, to include any supporting documentation as necessary Concur with comment. Inventory was being completed by student BMETS during their practical training. Currently, these BMETs are away undergoing officer training and the inventory will be finished after they return in February 2013.

13. Recommendation 6.b, Page 52, states:
NTM-A/CSTC-A, in coordination with MEDCOM and NMH, ensure that a process is established to cross-level medical equipment to ensure that the available equipment is properly utilized where needed.

a. NTM-A/CSTC-A Response Comments to DoD IG SPO Draft Report Recommendation 6.b:

Provide NTM-A/CSTC-A response and/or requested information, to include any supporting documentation as necessary Concur with comment. Cross leveling can commence once inventory is completed. The inventory is compared to Tashkil and excess equipment will be returned to the National Supply Depot for redistribution to facilities needing the item. The process will be completed once BMETs return from officer training, February 2013.

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14. Recommendation 7.a, Page 55, states:
NTM-A/CSTC-A, in coordination with ANA GSG4, MoD Acquisition Technology and Logistics (AT&L) and LOGCOM, ensure that procedures are established for the procurement, delivery and reliable availability of janitorial cleaning supplies, which includes disinfectants.

a. NTM-A/CSTC-A Response Comments to DoD IG SPO Draft Report Recommendation 7.a:
Provide NTM-A/CSTC-A response and/or requested information, to include any supporting documentation as necessary Concur – accomplished. The non-medical quartermaster officer for CIII (cleaning supplies), has created the requirements list and has submitted them to GSG4 for the procurement process.

15. Recommendation 7.b, Page 55, states:
NTM-A/CSTC-A, in coordination with MEDCOM, ensure that the Class VIII Authorized Stockage List is modified to include disinfectants and cleaning supplies. Additionally, ensure that these items are included in the 1392 and future Tashkils.

a. NTM-A/CSTC-A Response Comments to DoD IG SPO Draft Report Recommendation 7.b:
Provide NTM-A/CSTC-A response and/or requested information, to include any supporting documentation as necessary Concur – accomplished. Bleach, Dettol, hand sanitizer, and hand soap have been added to the CLVIII 1391 ASL. Units submitted their 1392 requirements to MEDCOM G4 at the beginning of December 2012.

16. Recommendation 7.c, Page 55, states:
NTM-A, in coordination with MEDCOM, ensure that the ANSF Healthcare Standards and the NTM-A/CSTC-A Validation Tool include criteria which is specific to the availability and use of disinfectants to properly clean and sanitize ANA healthcare facilities.

a. NTM-A/CSTC-A Response Comments to DoD IG SPO Draft Report Recommendation 7.c:
Provide NTM-A/CSTC-A response and/or requested information, to include any supporting documentation as necessary Concur – accomplished. Cleaning and sanitizing protocols as well as infection control, waste management training and cleaning schedules for Housekeeping staff are incorporated into the Validation Tool for Housekeeping.

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APPROVED BY:
Andrew J. Jorgensen
COL, USF
Command Surgeon

PREPARED BY:
[redacted]

Special Plans & Operations

Provide assessment oversight that addresses priority national security objectives to facilitate informed, timely decision-making by senior leaders of the DOD and the U.S. Congress.

General Information

Forward questions or comments concerning this assessment and report and other activities conducted by the Office of Special Plans & Operations to spo@dodig.mil

Deputy Inspector General for Special Plans & Operations
Department of Defense Inspector General
4800 Mark Center Drive
Alexandria, VA 22350-1500

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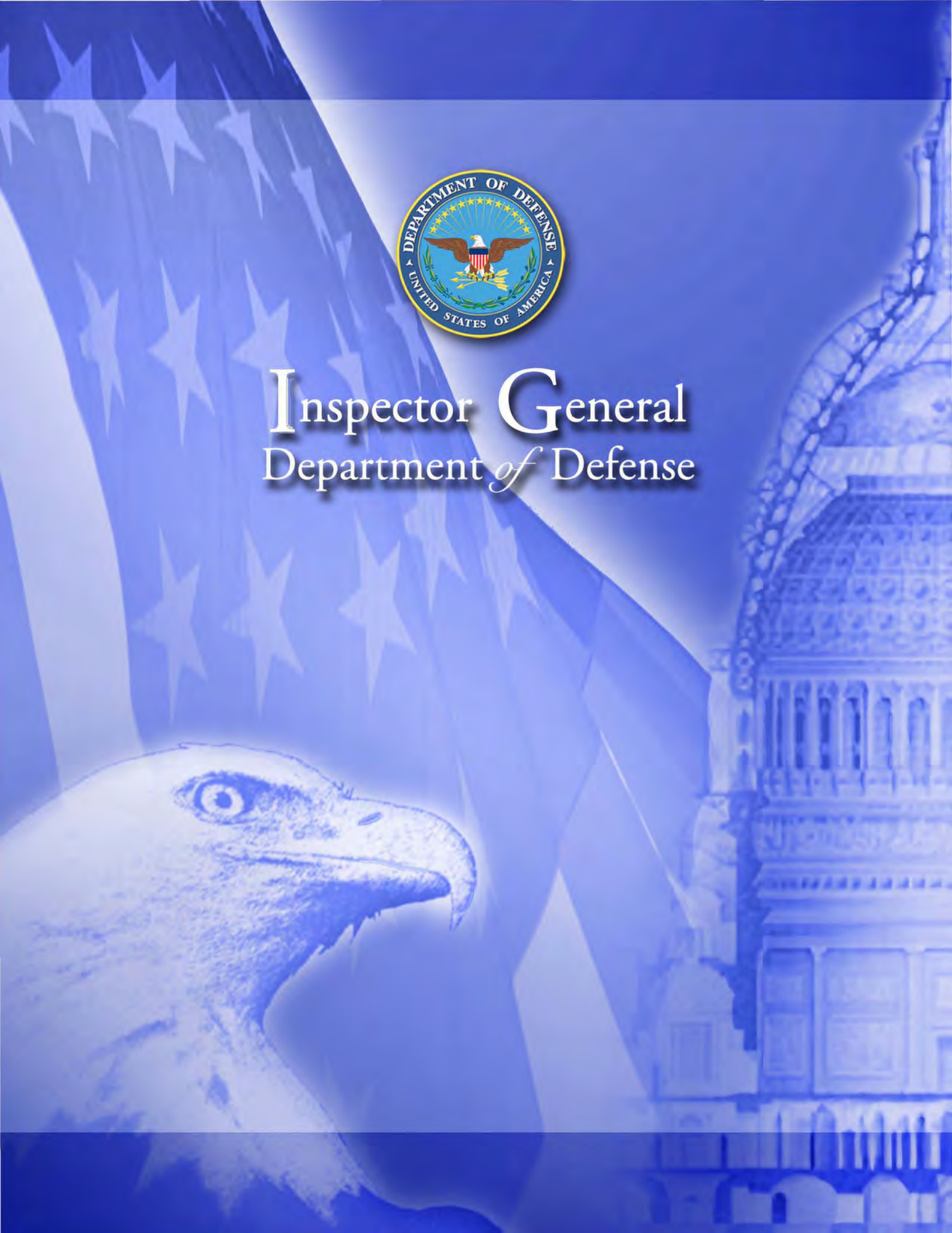
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