



THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

February 23, 2000

Ms. Elaine Kaplan
U.S. Office of Special Counsel
1730 M Street, N.W., Suite 300
Washington, D.C. 20036

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Office of Special Counsel

Dear Ms. Kaplan:

This is in response to your inquiry concerning Office of Special Counsel (OSC) File No. DI-99-1464.

Department of Veterans Affairs (VA) officials, including the Chief, Physical Medicine and Rehabilitation from the VA Ann Arbor Healthcare System, investigated each of the allegations brought forward in the complaint. A full narrative of their findings is enclosed. Although it was found that there was a lack of strict adherence to some procedures, there were no violations or apparent violations of any laws, rules or regulations. Irregularities in procedures have been rectified, and a number of management officials from the VA Ann Arbor Healthcare System are conducting periodic reviews of the work area.

Thank you for your letter concerning the issues at the VA Ann Arbor Healthcare System.

Sincerely,

A handwritten signature in black ink, reading "Togo D. West, Jr.", is written over the typed name. The signature is fluid and cursive.

Togo D. West, Jr.

Enclosure

**The Department of Veterans Affairs (VA) Investigation Results
VA Outpatient Clinic (OPC) in Toledo, Ohio**

I. A SUMMARY OF INFORMATION WITH RESPECT TO WHICH THE INVESTIGATION WAS INITIATED:

Management officials from the VA Ann Arbor Healthcare System reviewed the four allegations contained in the inquiry from the United States Office of Special Counsel (OSC) to the Secretary of Veterans Affairs dated August 19, 1999. The inquiry concerned allegations made by Ms. Patti Kessler-Franck, a former Physical Therapy Assistant with the Toledo Outpatient Clinic. The clinic is under the jurisdiction of the VA Ann Arbor Healthcare System. The allegations are: (1) Ms. Kessler-Franck claimed that she received chemical burns twice while cleaning the whirlpools and that the whirlpools are not flushed with water following the cleaning, resulting in several patients' negative skin reactions; (2) Ms. Kessler-Franck claimed that red hazardous bags were left open with dressings covered with blood and pus exposed; (3) Ms. Kessler-Franck was directed to provide a dirty disposable urinal to an elderly patient; and (4) Ms. Kessler-Franck observed that the disbursement pad sponges used in electric stimulation were stored on the back of the toilet in the Physical Therapy Department's bathroom. Ms. Kessler-Franck had voiced some of these issues while employed in December 1998 and a second time in her complaint to the Office of Special Counsel.

II. DESCRIPTION OF THE CONDUCT OF THE INVESTIGATION:

Upon receiving Ms. Kessler-Franck's first complaints, Leslie Westbury, Chief, Physical Therapy Section, VA Ann Arbor Healthcare System, ensured appropriate action was taken to improve adherence to procedures. In response to subsequent allegations, Ms. Westbury; Robert Werner, M.D., Chief, Physical Medicine & Rehabilitation (PM&R); and Mark Feigenbaum, Administrative Officer, Toledo OPC, reviewed the various allegations. Subsequently, Ms. Westbury and Lisbeth Nordstrom-Lerner, Infection Control Coordinator, made visits to the Toledo OPC to determine adherence to procedures. It was determined that the health, sanitation practices, and procedures were appropriate and adequate (see Attachment 1).

III. SUMMARY OF ANY EVIDENCE OBTAINED FROM THE INVESTIGATION:

Allegation 1: Staff was not using a measuring cup to determine the exact proportion of disinfectant to water; consequently, there was a higher proportion of disinfectant used than recommended by the directions listed on the container. When Ms. Kessler-Franck informed Ms. Westbury of this issue, Ms. Westbury visited the Toledo VA Outpatient Clinic to ensure that the proper technique was being used. The appropriate ratio of water to disinfectant is now being used. Ms. Kessler-Franck's supervisor, Ms. Prasad, stated she did not direct her to use the incorrect ratio. Although the VA Ann Arbor Healthcare System is uncertain why staff, including Ms. Kessler-Franck, did not verify the directions and use the proper

measurements to ensure the exact proportions were used as recommended, the VA Ann Arbor Healthcare System can verify they are now accurately maintained. To ensure exact proportional measurement, the manufacturer's squirt pump top was obtained, as were a measuring cup and tablespoon; these are now used at all times.

There have been no known patient injuries or rashes that could have been attributed to this cleaning procedure. Additionally, no patients became worse due to this sanitizing agent nor were there any patient complaints.

Ms. Prasad demonstrated to Ms. Kessler-Franck during her orientation the importance of back flushing the tanks and using clean water to ensure all of the sanitizing/disinfectant agents had been flushed from the agitators and the tanks. Ms. Kessler-Franck did not appear to understand the need for this and, in fact, reported that she had not done this at her previous facility. Ms. Prasad again explained the importance of this particular procedure.

It should be noted that when Ms. Kessler-Franck reported for work on a Monday, she informed Ms. Prasad that she had received "chemical" burns the previous Friday. At that time, it was observed that she did have several small-reddened spots (no blisters or wounds) on her forearm. A review of the product information showed that, for this sanitizing agent, there is no delayed reaction with a chemical burn. If these spots had occurred on the previous Friday, Ms. Kessler-Franck should have immediately reported the incident to her supervisor or the Toledo OPC Administrative Officer. The Material Safety Data Sheet states that the affected area should be flushed immediately with water to prevent a burn. Additionally, it should be noted that, according to Ms. Prasad, Ms. Kessler-Franck worked that weekend at a community nursing home where she was responsible for providing hydrotherapy treatments. Since Ms. Kessler-Franck mentioned the spots on Monday rather than Friday, one questions whether the "burns" were sustained during her tour of duty at Toledo OPC, or her second job at the community nursing home. Although Ms. Kessler-Franck did not seek medical attention at the Toledo OPC, she did eventually complete an Incident Report.

Allegation 2: After Ms. Kessler-Franck spoke to Ms. Westbury about this issue, Ms. Westbury went to the Toledo OPC to review the situation; at that time she instructed Toledo OPC staff to use one red bag per patient until a foot pedal waste container could be obtained; the bag was to be closed and then discarded in a large biohazard container. Since that time, the Toledo OPC Physical Therapy (PT) Department has obtained a closed-lid, foot pedal-operated waste container. The double bag method is used; at the end of each day, or when full, the container is emptied. Ms. Westbury notes that there is also one large biohazard disposal container in the hydrotherapy room. This container is provided by warehouse staff. PT staff are required to seal the box when filled with red bags and take it to the warehouse for proper disposal. Toledo OPC cleaning crews do not dispose of red bags. PT staff are asked to keep this particular box behind a closed curtained area in the hydrotherapy room. When the biohazard box is full, it is secured and given to

the supply supervisor or designee for transport to the VA Ann Arbor Healthcare System for final disposal. When dressings are malodorous, they are immediately bagged and sealed. PT practices in this area are consistent with those listed for "Standard Precautions," previously referred to as "Universal Precautions." Standard Precautions are the procedures governing infection control practices for all VA healthcare facilities.

During Ms. Kessler-Franck's tenure, staff found that one open red bag had been placed in a small wastebasket and reused several times; it is not true that the bag was not allowed to be emptied until completely filled with dirty dressings. Bags were disposed of at the end of the day at the minimum. On one particular day, a patient put several unsoiled bandage pads in this red bag; it was not sealed and discarded immediately.

Allegation 3: This incident occurred in December 1998. Rarely is a urinal needed in the Toledo OPC PT Department; however, one is kept in the staff bathroom in the event of an emergency. In this particular instance, Ms. Kessler-Franck asked Ms. Prasad for a urinal. Ms. Prasad stated the urinal located in the staff bathroom should be used; she explained to Ms. Kessler-Franck that it had not been used previously. Ms. Prasad did not actually see the state of the urinal, which apparently had been stored there unused for several months. Ms. Kessler-Franck knew it had been unused for several months, but noted it had collected dust and dirt; it seems reasonable to expect that the dust could have been easily rinsed off and the urinal dried. Ms. Prasad did not direct Ms. Kessler-Franck to use the dirty urinal. In the meantime, the patient got up and walked to the patient bathroom. Since then, several clean disposable urinals have been provided to the PT department. Staff was instructed not to store them on the floor, but to place them in the cupboard in the hydrotherapy room.

Allegation 4: In the PT staff bathroom, electrode sponges were stored in a blue bowl on the sink. All three staff were using this sink area as convenient work space for cleaning electrode sponges. Since this is not a patient or public bathroom, all PT staff using the area were aware of the electrode sponge situation. Once sponges are used, they are washed with disinfectant soap and water in the sink and placed in the blue bowl to dry; when they are reused, they are again washed with disinfectant soap and water. Because of the concern expressed by Ms. Kessler-Franck about the perception these may be used for toilet cleaning, the bowl was moved to the hydrotherapy room; dry sponges are now stored in a drawer under the appropriate ultrasound electrical stimulator machine. There was no intent to store this bowl, with these sponges, on the back of the toilet. However, the staff concedes that when the cleaning crew cleaned the sink, the bowl may have been displaced to the back of the toilet. At that point, any staff, including Ms. Kessler-Franck, should have moved the bowl to its proper location. There was no directive by Ms. Prasad that the bowl/sponges must be kept in this area. Ms. Kessler-Franck could easily have moved the bowl to the hydrotherapy room if she was concerned.

IV. LIST ANY VIOLATION OR APPARENT VIOLATION OF LAW, RULE OR REGULATION:

There were no violations, or apparent violations of any laws, rules, or regulations.

Although lack of strict adherence to some operating procedures did apparently occur, they have been rectified. On two subsequent visits to the Toledo OPC by Ms. Westbury, she noted the disposable urinals were kept on a shelf in a closed storage area in the hydrotherapy room, the electrode sponges were in the hydrotherapy room, and proper use of infection control procedures were maintained. Toledo OPC staff have been abiding by all appropriate procedures.

V. DESCRIPTION OF ANY ACTION TAKEN OR PLANNED AS A RESULT OF THE INVESTIGATION:

Ms. Kessler-Franck's initial complaints while she was employed were fully addressed at that time. Specifically, Ms. Westbury made a visit to the Toledo OPC to review her complaint and begin addressing the problem.

The complainant, Patti Kessler-Franck, was terminated on April 2, 1999, during her probationary period for breach of patient confidentiality, disruptive behavior, and portraying herself to be a Physical Therapist.

Ms. Westbury, Ms. Nordstrom-Lerner, and Mr. Feigenbaum will continue to monitor the Toledo OPC for compliance to infection control policies.

VI. CONCLUSION:

In summary, the VA Ann Arbor Healthcare System does not believe the four allegations represent a danger to the public. At the time they were brought to Ms. Westbury's attention, it was determined that improved adherence to procedures by all Toledo OPC Physical Therapy staff was necessary. Although these issues have been long remedied, ongoing monitoring of the department by Ms. Westbury and Mr. Feigenbaum continues to ensure full compliance.

In addition to personal observation by Ms. Westbury, Ms. Nordstrom-Lerner, and Mr. Feigenbaum, other staff (PM&R physicians, administrative staff, etc.) making periodic visits to the Toledo OPC have been asked to audit the area. A survey sheet of areas/items to check was recently made by Ms. Westbury; staff members visiting the Toledo OPC are required to return the completed survey form to her once they return to the medical center.

ATTACHMENT 1

Date: July 2, 1999
From: Lisbeth Nordstrom-Lerner, Infection Control Coordinator (1111)
Subj: Surveillance Report from Toledo OPC Physiotherapy
To: Dr. Carol Kauffman (1111)

1. On July 2, 1999, I conducted a regular surveillance round of the VA Toledo Outpatient Clinic including the Physiotherapy Department with two members of the staff.

2. I found the Physiotherapy Department clean and neat from Infection Control standpoint taking in consideration the old facility and the space available.

- Horizontal surfaces were wiped.
- Equipment was clean including the hydrotanks.
- The floor is old and worn. The floor needs stripping.
- The gray electrode patches are used for one patient only. After use on intact skin, they are placed in an envelope with the patient's name. They are washed before use. They need to be wet when in use to function.
- The rest room needed extra cleaning around the toilet.
- Dirty linen is placed in uncovered hampers. I suggest the department order hampers with a lid. *(Already received)*

/s/

LISBETH NORDSTROM-LERNER

cc: Leslie Westbury