



THE SECRETARY OF VETERANS AFFAIRS

WASHINGTON

July 16, 2002

Ms. Elaine Kaplan  
U.S. Office of Special Counsel  
1730 M Street, NW  
Suite 300  
Washington, DC 20036-4505

Dear Ms. Kaplan:

This is in response to your letter dated March 15, 2002, regarding public health and safety issues reported by an employee of the Department of Veterans Affairs (VA) Medical Center in Little Rock, Arkansas (OSC File DI-02-0308). VA's report on this matter is due on July 17, 2002.

This investigation was initiated following a report to your office that two VA nurses in supervisory roles were abusive to patients. The VA facility completed an Administrative Board of Investigation (Board) into this matter. The Board concluded that there was evidence indicating that these nurses were abusive toward patients. The nurses were moved out of direct patient care assignments, and the Chief, Nursing Service, proposed discharges for both nurses. One of the nurses resigned effective June 5, 2002. The other tendered her resignation on June 26, 2002, effective July 12, 2002. Our complete report on the matter is enclosed. The VA Inspector General also conducted an investigation at the facility. This investigation included, among other things, allegations against the two nurses referenced in your referral. A copy of the Inspector General's final report is also enclosed.

Thank you for the opportunity to respond to these issues. If you have further questions about the Board, please contact Mr. Dan Peterson, Chief, Human Resources Management Service, VA Medical Center, at (501) 257-1783.

Sincerely yours,

A handwritten signature in black ink, reading "Anthony J. Principi".

Anthony J. Principi

Enclosures

**REPORT TO OFFICE OF SPECIAL COUNSEL**

**Report of Complaint File No. DI-02-0308  
Office of Special Counsel**

**Prepared by:  
Central Arkansas Veterans Healthcare System  
Department of Veterans Affairs**



**Report Date: July 5, 2002**

**Table of Content**

**Table of Contents .....2**

**Executive Summary .....3**

**I. Introduction and Summary of Complainant’s Allegations .....4**

**II. Methods for Conduction the Investigation.....4**

**III. Summary of the Evidence .....5**

**IV. Violation or Apparent Violation of Law, Rule or Regulation .....6**

**V. Conclusions and Actions Taken .....7**

### Executive Summary

The Central Arkansas Veterans Healthcare System in Little Rock, Arkansas, was asked to review issues related to a complaint lodged with the Office of Special Counsel (OSC) by a Licensed Practical Nurse (LPN) ("complainant") employed on a unit of the North Little Rock campus. The allegations pertained to two other nurses working on the unit. The facility conducted an Administrative Board of Investigation (Administrative Board), and concluded that there was evidence to indicate that the nurses identified by the complainant had been abusive towards patients. The nurses were moved out of direct patient care assignments effective December 6, 2001. The Chief, Nursing Service, proposed discharges for both of these nurses. One of the nurses resigned effective June 5, 2002. The other nurse tendered her resignation on June 26, 2002, effective on July 12, 2002. The claimant's allegations (along with other issues involving the facility) are also the subject of an independent investigation by the VA Office of Inspector General (IG). The IG has reviewed the conclusions of the investigation, and advised that they agree with those conclusions. The IG will issue a separate report regarding their findings and conclusions.

## **I. Introduction and Summary of Complainant's Allegations**

The Secretary of the Department of Veterans Affairs (VA) was asked by the Office of Special Counsel (OSC) to investigate allegations by an LPN regarding conditions on a unit at the Eugene J. Tobin Healthcare Facility (VA facility) in Little Rock, Arkansas. The bulk of complainant's allegations pertain to a registered nurse who functions as a charge nurse on the unit (charge nurse). The complainant also alleges wrongdoing on the part of her first-line supervisor, the Nurse Manager of the unit.

The complainant alleges that the charge nurse mistreats patients and demonstrates a lack of regard for patient well being. The complainant alleges that the charge nurse is verbally abusive to patients, and cites one specific example where she verbally humiliated a patient. The complainant describes other situations where the charge nurse has deprived a patient of dinner or has ignored patient needs. Finally, the complainant alleges that the charge nurse has failed to report and document patient falls. The complainant also alleges that the Nurse Manager on her unit has interrupted her while she is engaged in administering medications to patients. Because of these interruptions, the complainant alleges on occasion, patients have not received their medications at the prescribed times. The complainant alleges that these and other actions by the Nurse Manager and the charge nurse demonstrate a pattern of mistreatment that is detrimental to the mental, emotional, and physical health of VA patients.

## **II. Methods for Conducting the Investigation**

An Administrative Board was authorized by the Medical Center Director to investigate complainant's allegations. A Clinical Psychologist from the Mental Health Service was Chairman. Board members included an Administrative Officer from the Environmental Management Service, and a Licensed Practical Nurse from the Nursing Service. The Administrative Board heard testimony from one patient on the unit, three former unit employees, 14 current unit employees, the Associate Chief Nurse for Extended Care, and the Assistant Nurse Manager of the unit. The Administrative Board also heard testimony from the Nurse Manager and the charge nurse identified by the complainant. In addition to the allegations raised by claimant, the Administrative Board also investigated the management practices of the Nurse Manager, as testimony heard by the Administrative Board indicated that her actions were affecting staff turnover and morale, thereby impacting patient care.

5.

### III. Summary of the Evidence

#### A. Charge Nurse

According to patient testimony heard by the Administrative Board, the charge nurse used harsh verbal language and would yell at patients. Additionally, two former employees and nine current employees testified that the behavior of the charge nurse was abusive to patients. Individuals who testified used the following words to describe her behavior: yelling, hateful, scolding, demanding, and disrespectful.

According to patient testimony heard by the Administrative Board, the charge nurse forced the patient to get up to eat. An employee testified that she witnessed this event. Five current employees also testified that two other patients were forced to shower or get up to eat. Three employees testified that the charge nurse failed to follow policy and procedures regarding reporting patient falls. Seven current employees and two former employees testified that the charge nurse spent long periods reading novels and neglecting patient care. While not directly relevant to the complaints received by OSC, other testimony suggested problems with the skills or work habits of the charge nurse. For example, six employees and one former employee testified that the charge nurse was unable to start an IV; two current employees and one former employee testified that she would not draw blood; and seven current employees and one former employee testified that she would not change dressings.

#### B. Nurse Manager

The complainant's specific allegation regarding the nurse manager was that she interrupted the complainant while she was passing medications to patients. With regard to this issue, one former employee and four current employees testified that the Nurse Manager would interrupt their patient care duties to discuss routine situations. All of these individuals testified that this was inappropriate, and that it negatively impacted patient care. The Associate Chief Nurse for Extended Care, Nursing Service, testified that such interruptions should be avoided.

In addition to the specific allegation raised by complainant, other testimony suggested problems with the Nurse Manager's treatment of patients. While the Nurse Manager had relatively little direct patient care, a unit patient testified that she talked down to him, would leave the room before he would finish speaking to her, and had a poor bedside manner. One former employee and five current employees testified that her behavior toward patients was abusive. The following words were used to describe her behavior: yelling, hateful, scolding, harsh, blunt, mean, and not compassionate. Three staff members testified that the Nurse Manager had witnessed the charge nurse verbally abusing patients, but took no

6.

action on the matter. Testimony from the patient and one staff member indicated that the Nurse Manager had taken patient's snacks and drinks.

Although not specifically related to complainant's allegations, testimony heard at the Administrative Board also suggested problems with the management skills of the Nurse Manager. Seven staff members testified that the Nurse Manager failed to take action to correct their complaints regarding inadequate staffing. Both current and former staff testified that the Nurse Manager exhibited favoritism in scheduling or assignments and did not treat employees equally. In this regard, the Assistant Nurse Manager testified that the Nurse Manager did nothing to address her concerns about the charge nurse. Some employees testified that the Nurse Manager responded to complaints by making heavier assignments. There was testimony from two former employees and nine current employees regarding the Nurse Manager's negative staff interactions. Two former and two current employees testified about their concerns regarding the way that the Nurse Manager responded to their requests for light duty. Seven employees testified that the Nurse Manager changed their assignments or schedules without notification. Six employees testified that the Nurse Manager did little to accommodate their leave requests. Six employees testified that the Nurse Manager did not advise them of their right to union representation during counseling. Five employees testified that staff meetings were held infrequently, and seven employees testified that the unit had no educational program.

In reviewing the issues raised by this investigation, the Administrative Board also discussed management's response to the allegations, including the response of the Assistant Nurse Manager, and the Associate Chief Nurse for Extended Care.

#### **IV. Violations or Apparent Violations of Law, Rule or Regulations**

The Administrative Board reported the following apparent violations of rules and policies:

A. Charge Nurse: The Administrative Board concluded that there was clear evidence of verbal abuse and mistreatment of patients. The Administrative Board concluded that the nursing skills of the charge nurse were below the standard of care. The Administrative Board also concluded that the charge nurse was willfully idle and failed to follow policy and procedures for reporting patient falls.

B. Nurse Manager: The Administrative Board concluded that there was evidence that the Nurse Manager inappropriately interrupted patient care. The Administrative Board also found clear evidence of verbal abuse of patients, and evidence of taking food items from patients. The Administrative Board found that the Nurse Manager failed to report that the charge nurse verbally abused patients. The Administrative Board found evidence of negative staff interactions, and that the Nurse Manager violated policies and procedures on light duty

7.

standards. They also found evidence that the Nurse Manager responded to complaints against her by mishandling schedule and leave requests. Finally, the Administrative Board found that the unit's educational needs were not met and that staff meetings were held infrequently.

## **V. Conclusions**

### *Recommendations from the Administrative Board:*

The Administrative Board recommended that the charge nurse's grade be reduced to an appropriate level to her nursing skills, with reduction in pay. If retained at the VA, she should work in an area where her interactions may be observed. She should not be allowed assignments where she has supervisory responsibility. Internal and external customer satisfaction should be closely monitored. The facility should quickly investigate any concerns and terminate her employment if any infractions occur. The Administrative Board also recommended reporting its findings to the State Board of Nursing.

The Board recommended removing the Nurse Manager from her position with a resulting reduction in pay. If retained at the VA, she should not have supervisory responsibilities and should work in an area where her interactions with patients and staff may be readily observed. Internal and external customer satisfaction should be closely monitored. The facility should quickly investigate any concerns and terminate her employment if any infractions occur. The Administrative Board also recommended reporting its findings to the State Board of Nursing.

The Administrative Board recommended that the Assistant Nurse Manager receive a written counseling for failing to report the Nurse Manager's actions to the Associate Chief Nurse for Extended Care. The Administrative Board also recommended that the Associate Chief Nurse for Extended Care receive an admonishment for failure to adequately investigate concerns that were brought to her attention.

The Medical Center Director deferred all of their recommendations with the stipulation that HRMS/Nursing Service will review the information to determine appropriate action or actions to take.

### *Actions Taken by the Facility:*

Following the report from the Administrative Board, the facility has taken the following actions:

After completion of the Administrative Board and the VA Inspector General investigation, the Chief, Nursing Service proposed discharges for the charge nurse on May 28, 2002 and the nurse manager on May 24, 2002. The charge

8.

nurse resigned effective June 5, 2002. The nurse manager provided a written notice of resignation on June 26, 2002, with an effective date of July 12, 2002.

The Associate Chief Nurse for Extended Care received a proposed reprimand on June 3, 2002. The decision letter to reprimand and a performance improvement plan were given to the Associate Chief Nurse for Extended Care on June 27, 2002. The Assistant Nurse manager for the unit received a written counseling on June 3, 2002.

The facility has also initiated procedures to report the charge nurse and nurse manager to the State Licensing Boards. The policies and procedures that the facility will follow are set forth in VHA Handbook 1100.18, *Reporting and Responding to State Licensing Boards* (attached). A letter as notice of the intent to consider reporting to the State Licensing Boards was mailed to the charge nurse on June 24, 2002. The same process will follow upon the effective date of the nurse manager's resignation.

To ensure that patients receive their tube feeding or meal trays as scheduled, regardless of where they choose to receive their trays, the facility has implemented a tracking system. This system will ensure that patients receive their meals as scheduled. The facility is in the process of training staff on the importance of nutritional intake. This training should be completed by July 31, 2002.

To ensure that nurses follow established bar code medication administration (BCMA) procedures all licensed staff on the unit have been provided a copy of Medical Center Memorandum No. 00-46, titled, "Administration of Medication using BCMA" which outlines the facility's BCMA policies and procedures. These policies and procedures will be discussed at monthly staff meetings. This should be completed by August 16, 2002.

The facility has implemented the Expert Panel Staffing Methodology for the unit. This will evaluate the effectiveness of the management of the unit to determine if decisions regarding staffing, scheduling, and assignments are appropriately based on patient census and acuity level. The registered nurses have also received information and training on team nursing concepts and making assignments.

To evaluate and strengthen where necessary the responsiveness of Nursing Service managers to employee and patient concerns, all extended care nurse managers, assistant nurse managers, and the Associate Chief Nurse for Extended Care are enrolled in coursework for supervisory skills. This coursework will be completed by August 16, 2002. All staff have received Extended Care memorandum 118C-B-22, titled, "Patient/Family Concerns," which outlines the facility's policy on dealing with patient and family concerns.

9.

The Associate Chief Nurse for Operations, Nursing Service, a Human Resources Specialist, and a union representative, American Federation of Government Employees, Local 2054, have met with all shifts on the unit to explain the processes for reporting their concerns. These meetings were held to ensure that nursing employees express their concerns without fear of reprisal and assure them that their issues will be addressed.



DEPARTMENT OF VETERANS AFFAIRS  
Office of Inspector General  
Washington DC 20420

DATE: June 13, 2002

TO: Medical Center Director (598/00)

SUBJECT: Final Report – Healthcare Inspection – Patient Treatment and Employee Conduct Issues, Central Arkansas Veterans Healthcare System Little Rock, Arkansas – Report Number 02-00705-121

1. Purpose

The Department of Veterans Affairs (VA) Office of Inspector General's (OIG) Office of Healthcare Inspections (OHI) conducted an inspection to determine the validity of allegations of patient abuse, employee misconduct, and patient safety violations at the Central Arkansas Veterans Healthcare System (CAVHS) Little Rock, Arkansas. We performed this inspection in response to two inquiries; one from Representative Julia Carson (10<sup>th</sup> District, Indiana) and another from a constituent who wrote to Representative Mike Ross (4<sup>th</sup> District, Arkansas).

2. Background

The CAVHS is comprised of two campuses located in the city of Little Rock and the North Little Rock community. The complainant made several allegations concerning a charge nurse on Extended Care Unit [REDACTED] at the North Little Rock campus of the CAVHS, (b) (6) including that she had: treated patients abusively by withholding meal trays and yelling at patients; over-sedated a patient; and compromised patient safety protocols by assigning one nurse to administer all patient medications. The complainant listed additional concerns about the competency of the charge nurse and the performance of her duties.

The complainant also alleged that the Unit [REDACTED] nurse manager had taken soft drinks, purchased by a patient's family, from the patient's personal refrigerator without his permission on several occasions. The complainant further alleged that the nurse manager had demanded that nurses interrupt their administration of medications to patients to speak with her. (b) (6)

The complainant also alleged that both the charge nurse and the Unit [REDACTED] nurse manager had jeopardized patient safety because they were excessively absent from the unit to take smoking breaks. (b) (6)

Unit [REDACTED] is an Extended Care Unit on the North Little Rock campus of the CAVHS. An associate chief nurse (ACN) is responsible for all extended care nursing activities. Unit [REDACTED] charge nurses are registered nurses (RN) with supervisory responsibility for their particular shifts or tours-of-duty. The Unit [REDACTED] nurse manager has supervisory responsibility for the Unit [REDACTED] charge nurses and all Unit [REDACTED] staff nurses. (b) (6)

### 3. Scope and Methodology

We reviewed medical records, nurse assignment sheets, treatment logs, bar code medication administration (BCMA) records, patient incident reports, reports of contacts with customer service representatives, and pertinent facility policies. We reviewed employee exit interview reports and other e-mail communications. In addition, we reviewed the proficiency ratings, position descriptions, and recent performance appraisals of the charge nurse and the nurse manager.

We interviewed the complainant, both of the subject nurses, five Unit [REDACTED] patients, the sister of one patient, and the ACN responsible for extended care nursing activities. We interviewed eight nursing employees who had previously worked on, or currently were working on Unit [REDACTED] including the Unit [REDACTED] assistant nurse manager, RNs, licensed practical nurses, and nursing assistants (NAs). We also interviewed the social worker with responsibility for Unit [REDACTED] patients and an advanced practice nurse on the unit. (b) (6)

The inspection was performed in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

### 4. Inspection Results

#### Issue 1: Abusive Treatment of Patients

We substantiated allegations that both the Unit [REDACTED] charge nurse and nurse manager acted abusively towards patients. Although we found no evidence of direct physical abuse of patients by either of the nurses, the nature of the incidents described in the allegations and those in other incidents, which we discovered during the course of the inspection, are considered to be abusive. (b) (6)

CAVHS Memorandum 05-11, *Standards of Ethical Conduct and Related Responsibilities*, states, "...abuse of a minor nature constitutes such acts as speaking irritably, rudely, or harshly to a patient; indifference (ignoring or being unresponsive); or teasing a patient." Also, CAVHS Memorandum 00-61, *Patient Safety Improvement Program*, defines patient abuse as "...an act that can involve physical, psychological, sexual, or verbal abuse. Examples are intentional omission of care, willful violation of a patient's privacy, willful physical injury, intimidation, and harassment or ridicule of a patient. Intent to abuse is not necessary. Patients' perceptions of how they are treated are essential to determining whether abuse occurred. However, patients with limited or no cognitive ability can still be abused."

We interviewed 13 witnesses who verified that the charge nurse had treated patients abusively. For example:

- The charge nurse acknowledged that she denied two patients their meals because they stated they did not feel well enough to get out of bed to go to the dining room. She had instructed Unit [REDACTED] employees not to retrieve the patient's meal trays and/or provide the trays to the patients at bedside, which was the customary procedure. Both patients went without their meals. According to their medical records, both patients should have been encouraged to get out of bed as much as possible. However, neither patients' records contained approved and documented behavior modification plans. These plans are often used as therapeutic tools to encourage desirable behavior. In one case, employees reported hearing the charge nurse announce that no employee was to get the patient's tray "...because he is too lazy to get out of bed." There was no local policy that condoned withholding patients' meals. The charge nurse's actions actually negated the patients' established goals. One patient's treatment goal was to consume 75 to 100 percent of his therapeutic diet and avoid snacks. The other patient's care plan instructed staff to "...give the [patient] choices while giving care." (b)(2)
- Witnesses reported to us that they had frequently heard the charge nurse speak rudely and "roughly" to patients. Many of the charge nurse's comments about patients were reported to be insensitive and undermining of patients' dignity and privacy. Witnesses told us that the charge nurse repeatedly yelled at a bedridden patient when he called out for assistance instead of using his call light. This patient told us that the charge nurse hated him. We did not substantiate the allegation that the charge nurse was over-sedating this patient to keep him quiet.
- Customer service contacts for Unit [REDACTED] documented that the family of a patient, who had expired while on the unit, complained that the charge nurse was not compassionate when she called to inform them of the patient's death. (b)(2)
- A patient on tube-feeding complained to the facility's Customer Service Representative that the charge nurse told him that Unit [REDACTED] was out of his tube-feeding supplement and that there was "...none to be had." He further reported that an NA went to another unit and was able to retrieve six cans of the supplement, without difficulty. He complained that the charge nurse neglected to administer his 6:00 a.m. and 6:00 p.m. feedings the next day, and he had to pour his feeding supplement into the machine himself. When he reportedly asked the charge nurse about why this happened, she allegedly responded that she had just forgotten to administer his feedings. (b)(2)
- Many of the nursing employees we interviewed told us that the charge nurse neglected patients and frequently would refuse to do anything about problems brought to her attention by the staff regarding changes in patients' conditions.

We also verified allegations that the nurse manager demonstrated abusive behavior toward patients:

- Employees described the nurse manager's manner of speaking to patients as demeaning and degrading. They reported that she spoke to patients in this manner, in front of employees, visitors, other patients, and families, and demonstrated a lack of respect for patients. She reportedly caused them undue embarrassment.
- When a difference of opinion between the nurse manager and a patient occurred, witnesses reported that the nurse manager would typically not relent until the patient submitted to her will.

Several nursing employees on the unit told us they feared reprisal if they reported these behaviors. Others stated that they felt that nothing would be done about their concerns, as they had no one "...backing them up." One staff member reported that she heard patients and family members say that they were afraid to complain, as they feared the patients would not receive care.

We also reviewed minutes of the July 25, 2001, Extended Care Patient Council meeting, which documented residents' complaints that "...some of the employees talk to the residents with no respect..." and that "...the residents are still being ignored when they push their call lights." Although the minutes omitted specific employee names, the Unit [redacted] social worker told us that the patients were referring to the Unit [redacted] charge nurse and the nurse manager. The minutes also documented that the responsible ACN was informed that these were ongoing problems. (b)(6)

**Issue 2: Misconduct of Nurse Manager and Charge Nurse**

Based on evidence we reviewed, we concluded that the Unit [redacted] nurse manager and the subject charge nurse did not maintain adequate standards of ethical conduct in their dealings with employees, patients, and families of Unit [redacted] patients. (b)(6)

CAVHS Memorandum 05-11, *Standards of Ethical Conduct and Related Responsibilities*, states, "...employees in the VA shall maintain the highest possible standard of honesty, integrity, impartiality, and conduct." It further states that employees "...shall avoid misconduct and conflicts of interest through informed judgment as an indispensable means to the maintenance of these high standards."

We confirmed that the Unit [redacted] nurse manager frequently took soft drinks from a patient's personal refrigerator without the patient's permission. Several witnesses verified this allegation, as did the affected patient. The patient told us that on one occasion, he had offered the nurse manager a soft drink. He stated that after that, she would inform him after the fact that she had taken another of his soft drinks. When asked if he minded this, he stated, "Yes, my family brings these in." He then reported that the nurse manager asked him daily for artificial sweetener for her coffee, which his (b)(6)

family also purchased for him. No evidence came to our attention that the nurse manager had taken things from other patients.

We confirmed that both the Unit [redacted] nurse manager and charge nurse were frequently absent from the unit to take smoking breaks during their tours-of-duty. CAVHS Memorandum 05-46, *Hours and Tours of Duty*, states, "...supervisors may grant two rest periods normally not to exceed 15 minutes each during any 8-hour tour of duty to full-time employees." Both of the nurses acknowledged that they took more frequent breaks than were allowed by policy. They told us that they did not take the allotted 30-minute lunch break, but instead took five 6-minute smoking breaks. They also asserted that they divided their two 15-minute breaks into six 5-minute smoking breaks, which would have caused them to be away from the unit as many as 11 times during an 8-hour shift. We concluded that these actions detracted from fulfillment of their supervisory responsibilities, and that these practices violated the spirit and intention of the break policy. (b) (6)

We did not find a correlation between the frequent smoking breaks and reported patient incidents. However, we interviewed 10 witnesses who reported that the charge nurse would leave the unit to take a break during periods of time when they felt that her presence was needed on the unit. They also charged that the charge nurse spent more of her duty time sitting at a desk than being directly involved in patient care.

CAVHS' *Standards of Ethical Conduct* policy addresses work attitudes and behavior. The ethics policy states that willful idleness or wasting time, and inattentiveness to duty are improper. We found nursing assignment sheets that showed that the charge nurse delegated more patient care to others than did other charge nurses. Witnesses told us that the charge nurse would refuse to do many of the less appealing aspects of patient care required of RNs, such as relieving an impacted bowel or treating a skin ulcer.

CAVHS Memorandum 05-6, *Employee Rights Relating to Patient Care*, states that an employee involved in the provision of patient care may ask not to participate in a specific aspect of care if there is a sincere belief that such participation is a violation of the employee's cultural values, individual ethics, or religious beliefs. Even then, efforts are to be made to honor such requests only when doing so will not negatively affect patient care or treatment. We did not find any evidence that the charge nurse submitted a written request to be relieved of any aspect of patient care. An employee's distaste for a task is not adequate justification for increasing the workload of other nursing employees.

We found documentation that the Unit [redacted] nurse manager and the responsible ACN were both aware of the charge nurse's work behaviors. The ACN received complaints from two employees of another unit to which the charge nurse was detailed for 1 day. They reported the charge nurse's "rudeness" and "unprofessional" attitude. (b) (6)

The Unit [redacted] nurse manager, who also is a subject of this hotline complaint, completed the charge nurse's proficiency evaluations in 1999 and 2000. The nurse manager wrote (b) (6)

that the charge nurse "...needs to be more aware of her communication skills," and that she "...needs to be more aware of staff assignments; to be more available to staff to assist with their patient assignments; and to have staff input regarding patient assignments." The nurse manager had recommended that the charge nurse seek out training on charge nurse duties and staff-to-patient assignments. However, we did not find evidence that this had been accomplished.

We also found that the charge nurse made inaccurate statements to us regarding her medication cart assignments to unit nurses. The *Standards of Ethical Conduct* state "...willfully inaccurate testimony in connection with an investigation or hearing may be grounds for disciplinary action." The charge nurse vehemently denied ever assigning a nurse to administer both medication carts as alleged. She told us that it would be almost impossible for one nurse to manage this task alone. However, we found assignment sheets that showed that on several occasions, the charge nurse had in fact assigned one nurse to administer all medications, even during the day shift, when as many as 40 patients could require several medications. The assignment sheets refuted the charge nurse's statements to the OIG inspector and illustrated potential patient safety vulnerabilities.

### Issue 3: Violations of Patient Safety

Both the nurse manager and the charge nurse were accused of practices that could potentially compromise patient safety. We substantiated the allegation that the charge nurse's practices on the unit, her unwillingness in some instances to perform certain duties, and her lack of skill in others, could compromise patient safety and/or diminish the quality of patient care.

For example, witnesses told us, and the Unit [REDACTED] nurse manager confirmed, that the charge nurse had an aversion to changing wound dressings. We were told that on several occasions the charge nurse did not change dressings as assigned and on some occasions failed to assign anyone else to change the dressings. We verified that the charge nurse did not provide medicated treatments to one patient as ordered on 3 out of 4 consecutive days. However, we could not determine if the charge nurse omitted other patients' ordered dressing changes or medicated treatments because records were unclear on who was assigned to do dressing changes. We also found inconsistent methods of documenting the administration of medicated treatments. (b) (6)

The subject charge nurse's method of administering medications to patients appeared questionable. Witnesses told us that the charge nurse frequently administered patient medications in considerably less time than the time required by most other nurses. We reviewed BCMA records of the charge nurse's medication rounds and found frequent and/or long breaks in her rounds. There were many early and late medication administration times entered into the BCMA records of her medication rounds.

For example, according to BCMA records, the charge nurse once administered eight medications to six patients (some of whom were in different rooms) in only 3 minutes.

We determined that it would be impossible for her to follow proper procedures in this small amount of time. It was simply not possible for a person to push the medication cart into each room and scan each patient's armband in only 3 minutes. On another occasion, BCMA records showed that the charge nurse administered 80 medications to 16 patients in 31 minutes.

The charge nurse acknowledged to us that she sometimes "pre-prepared" medications for patients, which she also acknowledged violated policy. The CAVHS medication policy requires that nurses prepare, administer, and document each medication for one patient at a time, before proceeding to the next patient. The charge nurse made a reported medication error, in which she omitted medication in preparation for a procedure. This resulted in cancellation of a patient's scheduled colonoscopy and esophagogastroduodenoscopy.

We did not confirm that the charge nurse's assignment of only one nurse to administer both medication carts was a violation of policy or that doing so necessarily posed a risk to patient safety. The relevant Nursing Service policy on the administration of medications does not specifically consider this practice to be a violation. In fact, other charge nurses occasionally made similar assignments but rarely at the heaviest medication times (e.g., the 9:00 a.m. medication pass). The charge nurse had assigned one nurse to handle two medication carts at heavy medication periods. While this practice does not violate policy, it can increase chances for medication errors. Employees told us that handling two medication carts was extremely difficult for one nurse to manage.

The charge nurse's September 21, 2001 proficiency report showed that she was unskilled in feeding tube placement and in obtaining intravenous (IV) access (that is, starting IVs), both of which are among duties required of a Nurse Level II (the charge nurse's grade). Because charge nurses may often be the only RNs on particular shifts, it is imperative that these nurses be proficient in all skills required of a Nurse Level II. The charge nurse's supervisor (the subject nurse manager) had recommended, but had not arranged for additional training on these proficiencies for the charge nurse.

We did not confirm or refute that the nurse manager's practice of interrupting medication rounds necessarily jeopardized patient safety or violated policy.

**Issue 4: Management Deficiencies on Unit** [REDACTED]

During the course of our inspection, we found the following documentation and scheduling deficiencies on Unit [REDACTED] (b) (6)

- Medical records were in disarray; many were without section labels, and the documentation sections within the records were inconsistently arranged.
- Only two of five active medical records we reviewed contained current advanced directives. We found clinical warnings posted on the computerized patient record

system cover sheets indicating the need to update the advanced directives on two patients. One of the two patients was admitted in April 2001, yet his advanced directive was last updated in 1999. The update is required annually.

- The ACN could not find current care plans that should have been printed and accessible for any of the patients on the unit. She told us that Unit [REDACTED] was not utilizing care plans as required. During our inspection, we asked to see patient care plans and Unit [REDACTED] employees had to create the plans for us. (b)(6)
- Unit [REDACTED] nurse assignment sheets were incomplete, confusing, and inconsistent. Many did not indicate which nurse was to administer medications. Some were undated or did not identify the shift. The "Master Assignment Sheet" required by Nursing Service policy was not being used. (b)(6)
- CAVHS medication administration policy required that medicated treatments (e.g., for wounds) be entered in the BCMA system. However most nurses were still using the manual entry form. Manual entries in the treatment log sheets were incomplete. Rarely did we find a notation of a missed treatment, and when a notation was present, it was rarely accompanied by an entry explaining the reason for the omission as is required by facility policy.

Employees told us about nurse scheduling problems. The nurses we interviewed complained that scheduling of staff was not done fairly or appropriately. They told us that there were frequently too many nurses at times when they were not all needed or too few nurses at times when needs were greatest. They felt that favoritism played a role in the scheduling. They also told us that punitive scheduling had occurred. We found documentation that these issues had all been reported to CAVHS Nursing Service managers, yet we did not find any evidence that managers took actions to address the alleged problems.

#### **Issue 5: Responsiveness of Nursing Administration to Deficiencies**

Despite significant evidence of problems, the responsible ACN did not take sufficient actions to improve conditions on Unit [REDACTED]. (b)(6)

The responsible ACN told us that the Unit [REDACTED] nurse manager was the weakest of the Extended Care Service Line nurse managers. The Unit [REDACTED] assistant nurse manager told us that the subject charge nurse was clinically one of the weakest RNs on the Unit. However, both the nurse manager and charge nurse continued to receive highly satisfactory performance ratings. (b)(6)

The ACN put the nurse manager on an "informal" Performance Improvement Plan (PIP) on August 25, 2000, as a result of multiple performance deficiencies. Twenty nursing employees signed a petition for the removal of the nurse manager, which prompted this action. Five private agency nurses had signed a petition regarding "...complaints

against working on unit [REDACTED] the previous month. The nurse manager's PIP cited the following deficiencies that required correction: (b) (2)

- Lack of responsibility and accountability for completing administrative tasks, including: submitting incident reports in a timely manner (some were older than 6 months); educating employees about policy and procedure changes; forwarding new employee satisfaction surveys; and completing probationary employee evaluations.
- Failure to establish effective relationships with customers (other services, interdisciplinary teams, employees, patients, and family members) as evidenced by the following:
  - Multiple complaints by Unit [REDACTED] employees related to inequities in staffing schedules. (b) (2)
  - Manner of communicating with employees was perceived by employees as hostile.
  - Did not demonstrate customer service standards in interactions with employees.
  - Multiple complaints received from other departments regarding the abrupt manner in which they were treated; thus they elected to avoid direct contact with her whenever possible.
- Failure to establish a unit-level monitoring system to evaluate compliance with Nursing Service policies and procedures as requested. Patient and family complaints and documentation deficiencies prompted this request.

One witness reported to us that the ACN responsible for extended care nursing activities told her that when she was hired, there were problems retaining staff on this unit because of the nurse manager. Also, it appears that Nursing Administration managers had received feedback from customers regarding problems with Unit [REDACTED] and its management, yet did not act accordingly. Incident reports, reports of contacts with customer service, and minutes of patient meetings documented problems with patient care, nursing documentation, and poor attitudes of the charge nurse and nurse manager. Additionally, six nursing employees who left Unit [REDACTED] between May 2000 and December 2001, cited problems with the nurse manager as one of the reasons for their departures. The ACN told us that 11 employees had transferred and 10 had resigned since the nurse manager began her tenure on Unit [REDACTED]. She also told us that two RNs had asked to be transferred, but decided to remain on [REDACTED] when the nurse manager was detailed away from the unit in December 2001. Ten employees (from Unit [REDACTED] and other services) sent e-mail messages to the ACN between August 2000 and September 2001, complaining about the nurse manager. (b) (2)

We concluded that the responsible ACN did not take sufficient action to improve conditions on Unit [REDACTED]. She usually responded by gathering more information, yet it appeared that she did not act on the information. She explained that although she knew there were problems on the unit, she did not know the exact nature of the problems. However, information provided to us indicated that the ACN knew the nature of the problems for a long period of time, yet she did not act to improve conditions. Thus, patients and employees were unnecessarily exposed to continued verbal abuse, neglect, and harassment for more than 1 year. (b) (6)

## 5. Conclusions

The subject charge nurse and the Unit [REDACTED] nurse manager did not maintain the standards of ethical conduct required of employees with supervisory and patient care responsibilities. We found evidence of verbal abuse and patient neglect, a disregard for policies and procedures, and harassment of employees. In our opinion, the subjects' apparent disregard for customer service standards compromised patient safety and reduced the morale of employees under their supervision. In addition to creating a hostile work environment for employees, this situation adversely affected patient care. (b) (6)

Responsible supervisors did not take sufficient action in response to feedback from patients, families, and employees of [REDACTED] and other services regarding both nurses' behaviors, the management practices of the nurse manager, and the deficiencies in documentation and patient care on Unit [REDACTED]. Both subjects continued to receive highly satisfactory performance appraisals despite mounting evidence of their deficiencies and mismanagement, and the impact of these deficiencies on patients and staff. (b) (6)

## 6. Recommendations

The Medical Center Director needs to:

- a. Take appropriate action against the subject nurses for verbal abuse of patients and failure to perform their duties in accordance with policy and the ethical standards of conduct required of VA employees.
- b. Ensure that patients receive their tube feedings or meal trays as scheduled, regardless of where they choose to receive their trays.
- c. Ensure that nurses follow established BCMA procedures.
- d. Evaluate the effectiveness of the management of Unit [REDACTED] to determine if decisions regarding staffing, scheduling, and assignments are appropriately based on patient census and acuity level. (b) (6)

- e. Evaluate and strengthen where necessary the responsiveness of Nursing Service managers to employee and patient concerns.
- f. Ensure that nursing employees can express their concerns without fear of reprisal, and assure them that their issues will be addressed.

#### 7. Health Care System Director's Comments

The Director concurred with all of the recommendations. The Director's implementation plans and target completion dates are shown in Appendix A of this report.

#### 8. Inspector General's Comments

The Director agreed with the findings and recommendations, and provided acceptable implementation plans. We will follow up on the planned actions until they are completed.

  
ALANSON J. SCHWEITZER  
Assistant Inspector General  
for Healthcare Inspections

## APPENDIX A

## HEALTH CARE SYSTEM DIRECTOR'S COMMENTS



DEPARTMENT OF VETERANS AFFAIRS  
Central Arkansas Veterans Healthcare System  
4300 West 7th Street  
Little Rock AR 72205

OFFICIAL USE ONLY

May 30, 2002

In Reply Refer To: 598/05C

Assistant Inspector General for Healthcare Inspections (54)  
VA Inspector General  
801 I Street NW, Room 1018  
Washington, D.C. 20001

SUBJECT: Response to Draft Report (Project Number 2002-00705-HI-0120/HL-0268)

This is my second response to your letter of May 3, 2002, in which you requested that I review and comment on the above-mentioned draft report regarding Unit [REDACTED] at the Central Arkansas Veterans Healthcare System (CAVHS). Specifically, your letter requests that my comments state whether I concur or do not concur with the findings and recommendations of this report. (b)(6)

Certain issues in this draft report were thoroughly investigated by an Administrative Board of Investigation (ABI) that I authorized on December 13, 2001. Other issues and findings in this draft report were not investigated by the ABI. We have reviewed the evidence to support your findings for the five issues listed and concur with your findings. The following is our implementation plan for the recommendations that you made:

a. Take appropriate action against the subject nurses for verbal abuse of patients and failure to perform their duties in accordance with policy and the ethical standards of conduct required of VA employees.

IMPLEMENTATION PLAN: We have proposed appropriate supportable disciplinary and performance actions for the subject nurses. These actions will be taken in accordance with applicable disciplinary and performance procedures. The disciplinary actions should be completed within 45 days. The Performance plans should be completed within 90 days.

b. Ensure that patients receive their tube feeding or meal trays as scheduled, regardless of where they choose to receive their trays.

IMPLEMENTATION PLAN: We have already implemented a tracking system to ensure that patients receive their meals as scheduled. Appropriate training will be provided to staff on the importance of nutritional intake within 30 days.

APPENDIX A

c. Ensure that nurses follow established BCMA procedures.

IMPLEMENTATION PLAN: All licensed staff will review policies and procedures for BCMA administration within 30 days. We will continue to monitor medication incidents on a monthly basis.

d. Evaluate the effectiveness of the management of Unit [redacted] to determine if decisions regarding staffing, scheduling, and assignments are appropriately based on patient census and acuity level.

(b) (6)

IMPLEMENTATION PLAN: We will implement the Expert Panel Staffing Methodology within 30 days to ensure that staffing levels and scheduling are appropriate for patient census and acuity. We have already implemented the concept of team nursing to ensure that assignments on Unit [redacted] are equitable and appropriate. All RNs will receive additional training in making assignments and team leadership based on patient census and acuity levels within 30 days.

(b) (6)

e. Evaluate and strengthen where necessary the responsiveness of Nursing Service managers to employee and patient concerns.

IMPLEMENTATION PLAN: All extended care nurse managers, assistant nurse managers, and the Associate Chief Nurse are currently enrolled in coursework for supervisory skills for nurses. This coursework will be completed by August 16, 2002. Included in the coursework are modules involving relations with staff and patients. Staff will review medical center policy regarding receiving and responding to patient and family concerns.

f. Ensure that nursing employees can express their concerns without fear of reprisal and assure them that their issues will be addressed.

IMPLEMENTATION PLAN: The Associate Chief for Operations and a Human Resources Specialist have met with all shifts on Unit [redacted] to explain the processes for reporting their concerns. The Unit [redacted] employees were ensured that they would not be subjected to reprisal for expressing their concerns.

(b) (6)

I trust that this response will assist you with your final report. If you have any questions, please call Mr. Bruce Suskie, Human Resources Specialist, at (501) 257-1767.

Sincerely,

/s/

GEORGE H. GRAY, JR.  
Medical Center Director

## Appendix B

## DISTRIBUTION

VA Distribution

Secretary (00)  
Deputy Secretary (001)  
Chief of Staff (00A)  
Executive Secretariat (001B)  
Under Secretary for Health (105E)  
Chief of Staff to the Under Secretary for Health (10B)  
General Counsel (02)  
Assistant Deputy Under Secretary for Health (10N)  
Director, Veterans Integrated Service Network (10N16)  
Director, Central Arkansas Veterans Healthcare System (598/00)  
Medical Inspector (10MI)  
Chief Quality and Performance Officer (10Q)  
Director, Center for Patient Safety (10X)  
Chief Patient Care Services Officer (11)  
Deputy Assistant Secretary for Public Affairs (80)  
Deputy Assistant Secretary for Congressional Affairs (009C)

Non-VA Distribution

Office of Management and Budget  
U.S. General Accounting Office  
Congressional Committees (Chairmen and Ranking Members):  
    Committee on Veterans' Affairs, United States Senate  
    Committee on Appropriations, United States Senate  
    Subcommittee on Health, Committee on Veterans' Affairs, United States Senate  
    Committee on Veterans' Affairs, U.S. House of Representatives  
    Committee on Appropriations, U.S. House of Representatives  
    Subcommittee on Oversight and Investigations, Committee on Veterans' Affairs,  
    U.S. House of Representatives  
    Subcommittee on Health, Committee on Veterans' Affairs, U.S. House of  
    Representatives  
    Subcommittee on VA, HUD, and Independent Agencies, Committee on  
    Appropriations, U.S. House of Representatives  
Staff Director, Committee on Veterans' Affairs, U.S. House of Representatives  
Staff Director, Subcommittee on Oversight and Investigations, Committee on  
    Veterans' Affairs, U.S. House of Representatives  
The Honorable, Mike Ross, 4<sup>th</sup> District, Arkansas, U.S. House of Representatives  
The Honorable, Julia Carson, 10<sup>th</sup> District, Indiana, U.S. House of Representatives

**SAMPLE NOTICE OF INTENT TO REPORT  
LICENSED HEALTH CARE PROFESSIONAL**  
(Certified Mail, Return Receipt Requested)

(Date)

Dear \_\_\_\_\_:

It is the policy of the Department of Veterans Affairs (VA) to report to State Licensing Boards (SLB) licensed health care professionals whose clinical practice appears to have so significantly failed to meet generally accepted standards of clinical practice so as to raise reasonable concern for the safety of patients. Our legal authority to make these reports is Title 38 United States Code, Sections 501, 7401-7405 and their regulations.

Based upon the following, we are considering whether, under these criteria, you should be reported to SLB. Our records indicate (*NOTE: Repeat verbatim the Index of Charges, except for Tab references--do not include patient names*)

(SAMPLE INDEX OF CHARGES)

- a. On December 13, 1997, you treated patient W2345 and wrote that the patient has "unsteady gait and slow speech." On December 14 and 15, 1997, you diagnosed the patient as having a sinus headache. Later, the patient was diagnosed as having a brain tumor. Your misdiagnosis resulted in the patient not receiving proper treatment for several days and constitutes treatment and diagnostic error.
- b. Between approximately July 24 and September 23, 1997, you engaged in a sexual relationship with patient A2598, a member of your therapy group. Your conduct blurred the distinctions between the professional staff and patients and resulted in a relapse of the patient. Your conduct constitutes patient abuse.
- c. On May 25, 1997, you prescribed ampicillin to patient E3456 even though her medical records stated that she was allergic to penicillin. The drug caused the patient to have an adverse reaction which resulted in the hospitalization of the patient. Your actions constitute treatment error.
- d. On August 19, 1997, you went on leave for 2 weeks without transferring care of your patients. This lack of continuity of care resulted in an emergency situation involving patient S4956. His deteriorating condition was unattended for several hours while the nursing staff located a physician who was available and willing to intervene. This constituted patient abandonment.
- e. On November 24, 1997, the Sure-Med cabinet recorded that between 0200 and 0600, you withdraw four 2mg tubex of Ativan, one each for patients B40963, G9547, Q4747, and M3419. The medical records for all four patients' record show that each patient received only 1 mg.

August 11, 1998

While you state that you wasted the unused 4mg, the required procedures for documentation and witnessing of controlled substances as contained in Medical Center Policy Document 123-ABC were not observed. This failure to properly account for controlled substances constitutes medication documentation error.

If you have information that you believe should be considered regarding whether VA should report you concerning these matters, please submit such information to the above address within 14 calendar days from the date of receipt of this letter to the attention of ( insert name) who may be contacted at (000) 123-4567.

Providing information in response to this letter is voluntary. If you do not provide information, a decision concerning whether to report you to SLB will be made based on available information. Any information you provide is voluntary and will be maintained in VA system of record 77VA11 which may be available to SLB, similar licensing bodies, or to other types of law enforcement authorities under the Privacy Act routine use authority.

(Signature)  
Medical Center Director

August 11, 1998

VHA HANDBOOK 1100.18  
APPENDIX F

**SAMPLE REBUTTAL RESOLUTION MEMORANDUM**  
(From a Service Chief or Chief of Staff to an Organizational Head Such as a  
VA Medical Center Director)

From: Service Chief for Ambulatory Care

Thru: Chief of Staff

To: Director

Subj: Rebuttal Resolution Regarding Proposed Reporting to State Licensing Boards  
(SLB) of Jane Doe, R.N.

1. By letter of November 10, 19xx, Ms. Doe was notified of our intent to report her to appropriate SLB for five concerns which we believe meet the standard for reporting. By letter of December 14, 19xx, Ms. Doe replied to the intent to report letter and by letter of January 2, 19xx, an additional reply was received from her attorney. After consideration of that correspondence, I recommend that charge four be dropped as explained below and the other charges be reported as proposed. The adoption of this recommendation resolves all the contested and disputed issues raised in Ms. Doe's response to the notice of intent to report letter.
2. Neither Ms. Doe nor her attorney challenged or rebutted the first three charges regarding multiple medication documentation and administration errors and there is substantial evidence to support those charges. However, both Ms. Doe and her attorney challenge charges four and five regarding diversion of narcotics for personal use and patient mental abuse.
3. Ms. Doe denies the fourth charge alleging diversion of narcotics for personal use. The allegation is supported by the five documents under Charge Four: (1) the Sure-Med report that recorded Ms. Doe as the individual removing four Perocet pills on September 9 for patient W9754; (2) the patient's statement that the pills he received did not lessen his pain and those pills did not appear to him to be the usual ones he received; (3) Ms. Doe's documentation in his records that she gave him two pills each at 0100 and 0500; (4) the statement from Dr. Jones that patient W9754 was alert and able to record events accurately; and (5) the September 9 Report of Contact from James Brown that stated that he saw four pills (type unknown) on the night stand of patient W9754 when he first reported for duty at 0730 but the pills were not there after the shift change at 0800. She contends that she gave the medicine as charted, that the pills looked different because they came from a new supplier, and that the medicine observed may have been her own personal medicine that she took before leaving duty. The five documents relied upon do not present any reliable evidence of diversion of the four Perocet pills for personal use. Additionally, while I was able to confirm that we had a new supplier of Perocet pills that looked different, I was unable to confirm if the new pills were in use on the day in question. Under these circumstances, I do not believe that the charge of diversion for

personal use can be sustained and that is the reason for the recommendation that this charge be dropped from any reporting and that all references to the charge be deleted from any reports to be made to the SLB.

4. The fifth charge was that Ms. Doe mentally abused patient S3456 by her improper contact and conduct with him when she was a nurse on the psychiatric ward from May through August, 19xx. In her reply, Ms. Doe admits to improper contact and conduct with patient S3456 by her letters, telephone calls, and poems to him but denies that her conduct constituted "patient mental abuse" as alleged the notice of intent to report letter. I do not find any merit in the distinctions made by her and her attorney. I believe that there is substantial evidence to report the patient abuse as alleged. Under Charge Five in the Evidence File is an August 15, 199x, letter of proposed removal that contains the same allegations that are in our letter of intent to report. In her August 29, 199x, reply to her proposed removal, Ms. Doe admitted that she sent patient S3456 letters and poems that had romantic overtones and were suggestive of a personal relationship. However, she maintains that her letters and telephone calls were in response to his letters and calls to her. Her reply letter contained her apology for causing him "marital difficulty" and having his therapy team changed. Ms. Doe's admissions must be considered in the context that during the time of the letters and telephone calls, patient S3456 had just been discharged from 3 months as an inpatient on the psychiatric ward, and had just completed his first month as an outpatient in twice weekly therapy. Ms. Doe abused her professional relationship with patient S3456 and created harm in his personal life based upon the dependent relationship between therapist and patient and Ms. Doe's knowledge that her telephone calls to patient S3456 at home caused his wife to complain to the Psychiatric Service Chief that resulted in his reassignment to a new therapy team. Based on these facts, the characterization of Ms. Doe's interactions with patient S3456 as constituting mental patient abuse is reasonable, is supported by substantial evidence and should not be changed because of Ms. Doe's rebuttal.

5. In reaching resolution of the issues raised by the response letter, I have consulted with the supervisory officials who were involved in the initiation of the charges in the notice of intent to report and they are in agreement with my recommendations.

**SAMPLE DECISION MEMORANDUM FROM AN ORGANIZATIONAL HEAD  
SUCH AS A VA MEDICAL CENTER DIRECTOR (00)  
TO GENERAL COUNSEL (024)**

(Date)

From: Director, VAMC \_\_\_\_\_

To: General Counsel (024)

Thru: VISN (XXX)  
Chief Network Officer (10NC)

Subj: Disclosure to SLB

Name: John Doe, M.D.

Date Of birth: 10/4/36

Occupation: Physician

SSN: 000-00-0000

Last Known Address:

Licensure: New York #00000

Maine #0000

1. In accordance with the authority contained in VHA Handbook 1100.18, I have decided, based upon a careful review of the attached State Licensing Board (SLB) Reporting File, that there is substantial evidence to make a report to the \_\_\_\_\_ and \_\_\_\_\_ SLB regarding John Doe, M.D. In accordance with the Handbook, the file is submitted for your review to determine if requirements of the Privacy Act and other information disclosure laws have been met so that I can report that:

John Doe, M.D., so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients, when during his clinical performance as a general staff surgeon he made multiple diagnostic and treatment errors.

2. The sustained charge(s) of Dr. Doe's failures are contained in the Index of Charges at Tab(s) \_\_\_\_\_

3. The specific procedures were met as indicated:

a. Advisement Notice, Tab \_\_\_\_\_.

b. Notice of Intent to Report, Tab \_\_\_\_\_.

c. Response and Rebuttal Resolution Memorandum, Tab \_\_\_\_\_.

- d. All instances of conflicting evidence have been identified and resolved in the specific Unit of Evidence where the charges appear.
4. All unsupported charges and unrelated evidence and all information unrelated to the charges have been removed from the attached File. The SLB Reporting File is maintained and retrieved by the name of the subject professional and is filed in Privacy Act System of Records 77VA11, Health Care Provider Credentialing and Privileging Records –VA,.
5. The File has been edited appropriately, including redacting or blanking out or otherwise eliminating:
  - a. Charges and related information for which substantial evidence was lacking;
  - b. Harmful or personal information irrelevant to the sustained charges
  - c. Personal identifiers of patients are highlighted or otherwise marked to indicate how they will be redacted once the concurrence stage is completed; and
  - d. Records not authorized for release.
6. A copy of the File, as provided to the SLB, will be maintained at the facility.
7. Should additional information be desired, please contact, \_\_\_\_\_, who is familiar with this matter at (123) abc-1234, extension 456.

Signature  
VA Healthcare Facility Director

Attachments

**SAMPLE REPORTING LETTER TO STATE LICENSING BOARD**  
(Copy of letter to be forwarded to Chief Network Officer (10NC))

(Date)

(Address of SLB)

Dear \_\_\_\_\_:

In compliance with applicable authority be advised that there is substantial evidence that Jane Doe, R.N., so significantly failed to meet generally accepted standards of clinical practice so as to raise reasonable concern for the safety of patients by \_\_ (Insert summary statement here.) \_\_.

*(SOME EXAMPLES OF SUMMARY STATEMENTS ARE:*

1. *Making repeated and significant medication errors in (transcription) (administration) (documentation);*
2. *Making repeated and significant treatment and diagnostic errors;*
3. *Being unable to meet the health standards for his position;*
4. *Having an intimate personal relationship with a patient;*
5. *Abusing his position by engaging in a (business) (financial) (sexual) relationship with a patient;*
6. *(Verbally) (physically) (emotionally) abusing patients;*
7. *Making repeated (transcription) (administration) (documentation) with controlled medications;*
8. *Engaging in \_\_\_\_\_)*

The following identifying data are submitted:

Date of Birth: March 20, 19xx  
 Social security Number: 000-00-0000  
 Last Known Address: 5555 Twin Valley Road  
 Massachusetts License Number: 000000, Expires 3-20-2002  
 New York License Number 09394578599 Expires 3-38-2003

Questions in this regard may be referred to (insert name and title), at (Telephone number).

If you wish to obtain the relevant information contained in the State Licensing Board Reporting File in this case, please submit a letter to the undersigned which meets the requirements of subsection (b)(7) of the Privacy Act. A sample letter and instructions that will permit proper disclosure are enclosed.

(Signature)  
Medical Center Director

Enclosure (The enclosure is Appendix I)

August 11, 1998

VHA HANDBOOK 1100.18  
APPENDIX I

**SAMPLE PRIVACY ACT SUBSECTION (b) (7) LAW ENFORCEMENT LETTER  
FROM STATE LICENSING BOARD (SLB) REQUESTING VA's  
SLB REPORTING FILE**

(Official Letterhead Stationery)

(Date)

Director  
VA Medical Center  
One Veterans Drive  
Minneapolis, MN 55417

RE: John Doe, M.D.

Dear Madame:

Thank you for your recent correspondence of December 1, 199x regarding John Doe, M.D. A review of our records reflects that Dr. Doe holds an active unrestricted license in this jurisdiction. The Board requests that you submit the relevant portions of the SLB Reporting File to support your conclusion that Dr. Doe failed to conform to generally accepted standards of clinical practice so as to raise reasonable concern for the safety of patients.

As you may know, whenever issues of a professional's competence or harm to patients is raised, the Board has law enforcement authority to review the concerns and take action as may be appropriate to protect the public health. I understand that the requested information is contained in a system of records and its disclosure is governed by the Privacy Act, Title 5 United States Code, subsection (b) (7) of the Privacy Act permits the disclosure of the requested information to a governmental agency for a law enforcement activity. This Board is authorized by the *(INSERT APPLICABLE AUTHORITY SUCH AS: Physicians and Nurses Practice Act, found at Section 23.345 of the State Code )* to investigate Physicians, Dentists, and Nurses licensed by this State when information is received that substandard care may be occurring and for other purposes set forth in the cited Statute.

(This paragraph in brackets is to be used only when the letter is signed by a designee and not the Board Head – See following note.) [The Board's head has delegated to me the power to request records covered by the Privacy Act and a copy of that delegation is also enclosed.]

Should you have any questions or concerns, please contact me at (123) 345-6789. Thank you for your cooperation.

Sincerely,

(Signature)  
Board Head or Designee, as appropriate

August 11, 1998

Enclosures

*NOTE: For the VA to have Privacy Act disclosure authority the letter must be signed by the head of the Board or a person who has been designated to act for the head of the Board. A designee must be an official of sufficient rank to ensure that the request for records has been the subject of high level evaluation of the need for the information. If the request is signed by a designee, a copy of the designation of authority, specifically citing (b)(7) of the Privacy Act, must be enclosed. The text portion of a sample (b)(7) Privacy Act delegation from a SLB acceptable to VA follows: I am the Executive Director and head of the \_\_\_\_\_ State Board of Nursing. The \_\_\_\_\_ State Board of Nursing has authority under State Statute Section xx 1234 to investigate and monitor concerns about substandard health care practices. I understand that disclosure of information contained in a system of records is governed by the Privacy Act, 5 U.S.C. §552a. Subsection (b) (7) of the Privacy Act permits the disclosure of the requested information to a governmental agency for a law enforcement activity as set forth in State Statute ABC found at Section XX of the State Code.*

To assist me in carrying out my duties under the statute, I am delegating to the persons listed below my authority to request such information on behalf of the Board:

Deputy Executive Director  
Associate Executive Director for Investigations  
Associate Executive Director for Prosecution

This delegation is effective on \_\_\_\_\_, 199X. The current status of any person using the above titles may be verified by calling the Board's office at (123) 456-7898.

Sincerely Yours,

Mary Jones Smith, RN, MS, Ds N.  
Executive Director

## 15. RESPONDING TO INQUIRIES FROM SLB

### a. General

(1) As stated at the beginning of this Handbook, it is the policy of the VA to cooperate whenever possible with an inquiry by a SLB. Accordingly, consistent with the procedures set out in this Handbook and applicable information law, VA health care facilities will provide reasonably complete, accurate, timely, and relevant information to SLB in response to inquiries. Furthermore, while Federal Supremacy under the constitution could, under applicable circumstances, be invoked to prevent a State inquiry into the provision of care at a VA facility by a VA professional, consistent with the VA policy of cooperation with SLB, the use of this doctrine to prevent such an inquiry will seldom, if ever, be authorized. For example, if a Director or head concludes, following a Comprehensive Review conducted in accordance with this Handbook, that the reporting standard has not been met and the VA inquiry is properly terminated, the VA nevertheless ordinarily will cooperate with a subsequent inquiry initiated by a SLB, including making its SLB file available pursuant to a Privacy Act (b) (7) request, rather than to raise a Constitutional Federal Supremacy objection. Such an objection may be raised only upon concurrence by the CNO following consultation with the General Counsel (023).

(2) Because of the Privacy Act, a standing request for information, such as a request for information to be provided each time there is a clinical practice concern, cannot be honored. SLB should request specific information on a professional by a signed consent or Privacy Act law enforcement investigation letter similar to the sample letter of Inquiry from SLB in Appendix I.

(3) Occasionally the Freedom of Information Act (FOIA) is cited by SLBs as authority to request information on professionals. Generally, FOIA will not permit disclosure about specific professionals. SLBs should be advised to request the information with a signed consent from the individual in question or with a (b) (7) Law Enforcement Investigation Letter as outlined below.

### b. Signed Consent

(1) A signed consent from the subject professional is sufficient to disclose information, covered by the Privacy Act, about a currently employed or separated VA health care professional, in response to a request from a SLB accompanied by the consent.

(2) When relying on the signed consent for disclosure authority, the consent must have been signed within the 6 months prior to the date of the disclosure. It must state the individual or organization to whom the information may be released and the type of information that may be released. It is suggested that all release of information be handled with the advice and consent of the local Freedom of Information Act and/or Privacy Act Officer. Clarification may be sought from the Regional Counsel by that Officer in questionable cases, such as when VA receives a signed consent that specifies that VA may release any information "other than information that is derogatory," or, when the consent

does not specify the type of information that VA may release.

c. Privacy Act Subsection (b) (7) Law Enforcement Investigation Letter

(1) Generally, information compiled to meet the requirements of this Handbook will be released if a SLB's request for that information meets the requirements of the Privacy Act, 5 U.S. Code 552a, subsection (b) (7) following essentially the format of the sample Privacy Act Subsection (b)(7) Law Enforcement Investigation Letter in Appendix I. The request must:

(a) Be in writing on the SLB's letterhead stationery.

(b) Cite the State law giving the SLB authority to take action against professionals who hold such a license, certification, or registration.

(c) Identify specifically the individual about whom information is sought, the records desired, and the law enforcement activity for which the information is sought. *NOTE: This would usually indicate protection of the health of the State's citizens.*

(d) Be signed by the head of the Board or a person who has been designated to act for the head of the Board. If a designee is to sign the request letter, to be effective:

1. The designee must be an official of sufficient rank to ensure that the request for records has been the subject of a high level evaluation of the need for the information, even considering the privacy interests of the professional involved. Such an official would be at least at the supervisory level. Generally, a request signed by a line investigator is insufficient.

2. The designation from the head of the Board to the designee must accompany the request, and must state that the designee is authorized to make a request under the Privacy Act (b)(7).

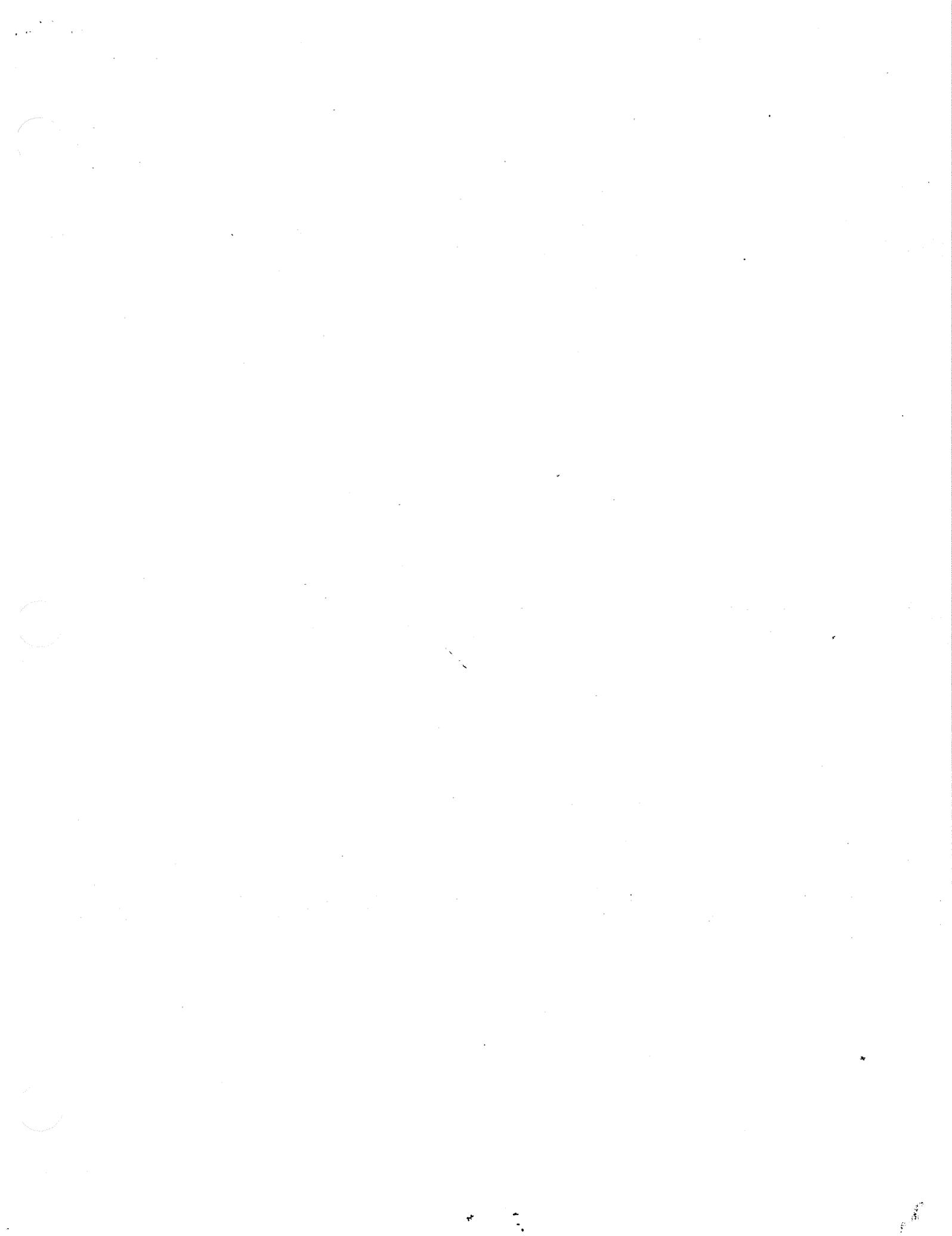
3. Such a letter should be substantially similar to the sample Privacy Act (b) (7) letter contained in Appendix I. A copy of this sample law enforcement request letter should be provided to the SLB to assist them in complying with this disclosure requirement.

(2) If there is any doubt, the Director or head should consult with the local Privacy Act Officer, and as needed, the Regional Counsel, to ensure that the SLB's law enforcement request complies with the Privacy Act requirements.

d. Subpoena. Occasionally, a SLB will request information pertaining to a professional by administrative or state court subpoena. The VA does not believe that the Privacy Act permits disclosure by subpoena. The Board should be advised that disclosure can be made with a signed consent or by a Privacy Act subsection (b) (7) law enforcement investigation letter. Questions concerning subpoena requests should be referred to Regional Counsel.

**16. INTERIM RESPONSE TO A SLB INQUIRY WHEN VA IS CONSIDERING REPORTING ON ITS OWN INITIATIVE**

When a request for information concerning a licensed health care professional is received from a SLB while a VA health care facility is considering reporting the individual, the facility should respond to the initial inquiry by stating that the Board's request is considered a serious matter; that a VA inquiry into this matter has been initiated; and that the request is being processed. The facility should expeditiously follow the five stages of procedures set forth regarding VA initiated reporting. Except when the statistical reporting procedures apply, the VA facility will not provide information to the SLB concerning the individual until after all procedures required for VA reporting have been met.



## OVERVIEW OF THE FIVE STAGE STATE LICENSING BOARD REPORTING PROCESS

### 1. INITIAL REVIEW STAGE: (Suggested Timeframe: Seven calendar days.)

a. Determine whether it initially appears that the behavior or clinical practice of a licensed health care professional so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients within 30 days of :

- (1) An employee's departure from VA rolls **or**
- (2) Receipt of information suggesting a current employee's provision of substandard care.

b. Proceed to Comprehensive Review stage if serious concerns are raised that suggest that the preceding reporting standard may have been met, **or** file in Privacy Act System of Records 77VA11, Health Care Provider Credentialing and Privileging Records -VA, (77VA11) under the employee's name a dated statement that an initial review determined no unresolved serious concerns regarding substandard clinical performance or behavior causing concern for patient safety.

### 2 COMPREHENSIVE REVIEW STAGE: (Suggested Timeframe: Forty-five calendar days.)

- a. Inform professional of concerns raised by Advisement Notice and seek professional's comments.
- b. Commence comprehensive review at time Advisement Notice delivered or sent.
- c. Review professional's response and note admissions, denials, or admissions with explanation.
- d. Develop additional facts as necessary to fully answer arguments or denials raised by the professional so as to resolve all contested issues.
- e. Prepare an Index of Charges with each charge supported by an organized unit of evidence that includes the professional's response to each charge.
- f. Remove and file in 77VA11 "Review Material - Not Substantial Evidence," as appropriate.
- g. Issue Notice of Intent to Report that details each charge of substandard care or behavior by date and incident.
- h. Deliver to and secure written acknowledgment from the professional of the notice; **or** make reasonable efforts to secure written acknowledgment of receipt when initial delivery efforts fail.
- i. Commence Decision Stage after documentation of additional reasonable efforts to effect

notification.

j. Remove patient identifiers and provide a redacted copy of the Evidence File to the professional upon request.

k. Prepare Rebuttal Memorandum resolving all issues disputed by the professional to the charges.

l. Remove and file in 77VA11 "Notice of Intent to Report – Not Substantial Evidence," as appropriate.

3. **DECISION STAGE:** (Suggested Timeframe: Seven calendar days)

a. Determine whether substantial evidence exists to report each charge in the Notice.

b. Determine whether reporting is indicated or appropriate considering the charges supported by substantial evidence.

c. Advise professional of a "total no report" decision and file "no report" review materials in 77VA11.

d. Prepare a Decision Memorandum when there are charges to be reported with the intended summary reporting statement.

e. Remove or redact from the Evidence File all documentation not relevant to the charges to be reported.

f. Augment the File as necessary to promote clarity and understanding of technical medical procedures or terms.

4. **CONCURRENCE STAGE:** (Suggested Timeframe: Thirty-five calendar days.)

a. Forward to the General Counsel through the Chief Network Officer the SLB File.

b. Review of file by CNO and General Counsel and preparation of concurrence memorandum.

5. **REPORTING STAGE:** (Suggested Timeframe: Seven calendar days.)

a. Prepare and send Reporting Letter to SLB with copy to Chief Network Officer (CNO) (10NC), Medical Inspector, and the professional.

b. File copy of reviewed "SLB Reporting File" under employee's name in 77VA11.

c. Prepare and send review materials properly requested by the SLB with deletions and redactions as indicated.

**GUIDELINES FOR COMPILING, ORGANIZING AND PREPARING THE STATE  
LICENSING BOARD REPORTING FILE AND DECISION MEMORANDUM**

1. **The Decision Memorandum and State Licensing Board (SLB) Reporting File.** The SLB Reporting File consists of documentation that accurately establishes whether or not a licensed health care professional has so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. The SLB Reporting File is filed and retrieved by the name of the licensed health care professional and is to be maintained in VA Privacy Act System of Records 77VA11, Health Care Provider Credentialing and Privileging Records -VA. The Decision Memorandum and the components of the SLB Reporting File, in the order forwarded to the General Counsel through the Chief Network Officer (CNO) are:

a. **The Decision Memorandum.** The Decision Memorandum is both a decision and transmittal document sending the file from the originating organizational head to the General Counsel through the. *NOTE: A sample copy of a Decision Memorandum is included in Appendix G.*

b. **The Response and Rebuttal Resolution Memorandum.** The Response is any information provided by the licensed health care professional. The Rebuttal Resolution Memorandum consists of a detailed statement addressing any conflict created by the Response. *NOTE: A sample copy of a Rebuttal Resolution Memorandum is included in Appendix F.*

c. **The Notice of Intent to Report.** These materials consist of a copy of the notice, and, documents showing either that the licensed health care professional received the notice, or, that reasonable efforts were made to provide such notice. *NOTE: A sample copy of a Notice of Intent to Report is included in Appendix E.*

d. **The Evidence File.** The Evidence File consists of all relevant records for each charge of failure to meet the reporting standard. The Evidence File consists of three parts filed in the following order: Advisement Notice documentation, an Index of Charges, and Evidence Units supporting each charge. Each Evidence Unit will include any relevant information from the professional. Each charge which the reviewer determines is supported by substantial evidence should be listed on a document known as the Index of Charges. Each Unit of Evidence supporting each charge should be a separate component of the file, such unit tabbed or otherwise marked to set it off from the other units of evidence for other charges. Units of evidence could include, but are not limited to relevant portions of documents from administrative boards of investigation; reports of contact; police reports; patient record information (including, in cases involving controlled substances, all relevant prescription and administration control records); copies of facility policies and procedures that identify the standards or requirements breached; and, relevant health information specific to the licensed health care professional. Also included would be signed statements from the charged licensed health care professional, staff or patients. Each charge listed in the Index should identify, by letter or number, the tab at which is located the Unit of Evidence supporting that charge.

## 2. Evidence Gathering Principles

a. **Overview.** When first commencing a review, exactly what happened and precisely what, if any, charges will end up being sent to a SLB often cannot be known. Hence, the reviewer may begin by interviewing the professional, some managers, other employees or patients, or gathering and reviewing records without having a particular focus. However, as the reviewer becomes educated in the facts surrounding the circumstances which gave rise to the concern about possible substandard care and harm to patients, the focus should become clearer. At that point exactly what charges should be considered, which records should be obtained, from whom statements should be taken and what questions should be answered in those statements becomes much more apparent. Collecting and organizing the relevant and important records and statements is the work of the reviewer. *NOTE: It should be noted that the purpose of the review is to obtain a fair and balanced portrayal of the events in question so as to enable the Director or other decision maker to make a properly informed decision on whether to report. Knowledge of a few basic principles concerning evidence in the SLB context may be useful in identifying the truly important evidence.*

(1) Relevant and Material Evidence. The primary limitation on the use of evidence in SLB proceedings is the requirement that evidence be relevant. Evidence is relevant when it relates to the charges of substandard care. Material evidence is that relevant evidence which is important to resolution of the issues in dispute. *NOTE: Material evidence is always relevant, but not all relevant evidence will be material.*

(2) Credible and Reliable Evidence. Relevant evidence is only persuasive when it is credible and reliable. Some factors to look at when weighing the credibility and reliability of evidence are the:

- (a) Source of the evidence is known;
- (b) Source is certain and positive concerning the evidence being offered;
- (c) Evidence from the source corroborates (comports with or is consistent with) other evidence from other sources;
- (d) Truthfulness of the source is not in doubt;
- (e) Opinion-type evidence, if the source is competent and qualified to render the opinion (as an example, statements regarding a professional's physical or mental ability to perform the functions of the position);
- (f) Source has no interest in the outcome of the concerns or has no bias against or hostility toward the parties;
- (g) Source's testimony is based on personal knowledge rather than hearsay;
- (h) Written or documentary evidence is legible, unaltered, and authentic; and

- (i) Source has made no prior inconsistent statements.

(3) Direct Evidence. Direct evidence should be collected; "indirect evidence" should be avoided as much as possible. Direct evidence demonstrates a fact - what occurred - itself, without passing through an intermediary. The records normally created in the provision of health care are direct evidence, since they are the record of what occurred, or at least, of what was entered. Thus, for example, in a situation where there is a question about the administration of medication, the usual records involved in medication administration provide direct evidence as to what was prescribed, copied, obtained and administered. In a drug administration case, these records should always be collected to demonstrate shortcomings by the licensed health care professional as to each and every allegation of misadministration intended to be reported to the SLB.

(4) Indirect Evidence. A statement which is based not on the witness's own personal knowledge obtained through the witness's own senses, but rather, on what the witness claims someone else said or wrote is "indirect evidence" or hearsay. Although generally not admitted into evidence in courts, hearsay evidence is admissible in administrative proceedings, such as SLB reviews, provided it is relevant. However, hearsay, unless corroborated by direct evidence may and often does have less credibility, and thus less value, than direct, non-hearsay since it is generally less reliable.

(5) Limited Value Evidence. Historically, reviewers in SLB cases have often collected considerable amounts of indirect evidence, often of a hearsay nature, which, at best, has limited value in establishing a basis for determining whether the reporting standard has been met. An example of indirect evidence records is the professional's performance evaluation. Such evaluations usually are written by one who is relying on activities witnessed by someone other than the writer. When a reviewer encounters indirect evidence related to a charge, reasonable effort should be made to pursue that lead to direct evidence to locate an actual witness to the event, for example, and obtain a signed statement from that witness. The statement from the witness can then be used as direct evidence regarding that charge.

#### **b. Use of Records as Evidence**

(1) Patient's Medical Record. If some of a patient's medical record provides evidence for determining that the licensed health care professional so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients, then a copy of the portion of the medical record proving the failure(s) should be obtained and included as part of the Evidence File. Redactions are to be completed before a copy is sent to the professional and before the file is forwarded through the CNO to the Office of General Counsel. This redaction will consist of deletion of the patient names and identifiers which will be replaced with a consistent anonymous patient identifier.

(2) Licensed Health Care Professional's Fitness for Duty Record. If a licensed health care professional retires or is separated due to a disability, and the disability was evaluated as part of a fitness for duty evaluation and the evaluation suggests that the professional may be so unable to meet generally accepted standards of clinical practice as to raise reasonable concern for the

safety of patients, a copy of the medical evaluation should be included as a part of the Evidence File. *NOTE: Important in this type of case are statements by medical experts regarding the impact of the disability on the clinical practice ability of the professional, and any evidence of substandard care of risk to patients attributable to the disabling condition.*

(3) Use of Evidence or Case Record Developed for an Administrative Proceeding such as a Disciplinary Board, Probationary Review Board. Generally, documents previously compiled for other purposes may be used in the Evidence File, but the use is limited to only those documents or portions of documents relevant to the charges in the proceedings outlined in this Handbook. Thus, the administrative investigation or other record may need to be reorganized, with portions deleted, to meet the compilation and organizational requirements of the Evidence File.

(4) Certain Records Prohibited from Use in Evidence File. Certain records may not be placed in the Evidence File; those records are the medical quality assurance records made confidential by law, i. e., Title 38 United States Code (U.S.C.), Section 5705 and implementing regulations, VHA Directives and local Issuances. One such document is a VA Form 10-2633, Patient Incident Report, created after January 23, 1995. A record covered by this protection may be examined by the reviewer and used to go to possible witnesses or treatment records to obtain includable direct evidence.

(5) A Brief Explanatory Note Helpful. Often, in a drug misadministration case, for example, the evidentiary value of the records may not be immediately apparent to a lay reviewer or an individual (such as a SLB official) not familiar with the facility's recordation system; or, possibly, the records may not be particularly legible. Accordingly, a good reviewer might include with the medication administration documents (or other evidentiary records) markings, notes, or brief explanations to help others understand what the record says and how it supports the particular charge.

### c. Use of Statements as Evidence

(1) Witness Statements. In addition to records, the other main source of evidence is a signed statement of someone who actually saw or heard an action or event. A statement from health care professionals, patients, visitors, or staff who actually saw the alleged patient abuse, for example, should be sought. As with records, witness statements should be of the direct evidence type. Thus whenever possible, they should be written in the first person specifically describing what, when and where an event happened, and who was present, e.g., "On June 19, 1998, around 6 p.m., while visiting my brother, Ronald Nelson in Room 404, I saw Nurse "A" slap Mr. Johnson, a patient and roommate of my brother." On the other hand, the statement, "I observed Dr. "Y" for 10 months and he was incapable of handling an emergency," is too vague and conclusory to be of much value. Indirect evidence and hearsay, such as "Nurse A told me that Dr. "W" frequently missed patient appointments," or an imprecise statement such as, "I don't remember exactly when, but Dr. "X". fell asleep during a procedure," generally will not suffice as evidence.

(2) Statement of the Professional. The law requires that the reviewer collect information to the greatest extent practicable directly from the licensed health care professional whose actions are in question. This means that the professional must be given the opportunity to provide a

statement concerning the possible charges at the earliest practicable opportunity. The professional should be advised of the substance of relevant supporting evidence against them so that a knowledgeable reply can be made. The advisement should conform to the Sample Advisement Notice to Licensed Health Care Professional in Appendix D. If the health care professional admits to actions or shortcomings, effort should be made to obtain a signed admission statement containing specific details. It is recommended that the signing be witnessed.

(3) Patient Statements. Reasonable effort should be made to obtain a signed statement from a patient when the patient can provide relevant information, such as when a patient states a medication was not received but it is documented that it was administered, or when a patient witnessed or was a recipient of abuse. A separate statement stating that the patient was unable to provide such a statement should be provided in all cases where a statement from the patient would be expected. If the medical condition of the patient raises doubt as to the reliability of a statement, a statement from a professional familiar with the patient should accompany the patient's statement; it should indicate that person's familiarity with the patient and offer an opinion as to the reliability of the patient's comments. Besides the reliability considerations, before approaching the patient, the reviewer should ascertain whether the physical or mental health of the patient would be compromised if asked for a statement.

### 3. Creating the Evidence File

#### a. Drafting the Charges

(1) At the outset of the review, there will probably be concern that certain specific actions or omissions constituting substandard care occurred. The review will initially focus on these, and indeed will often not need to go beyond these concerns to complete a competent inquiry. On other occasions, the inquiry might reveal that the initial concerns were "only the tip of the iceberg", or that the acts or omissions were somewhat misunderstood or mischaracterized when seen in the full light of the review. Thus, any charges finally drawn up when the review is essentially complete may be somewhat different than the charges one might have expected to write up at the outset of the review.

(2) At any rate, once the circumstances are reasonably well understood and evidence is in hand, the charges drafted must be drafted with care. Each substandard act or omission for which it appears there is substantial evidence should be identified in a charge. Each charge should describe one act or omission. The act or omission should be described with reasonable particularity, including the date, a description of the acts or omissions, the standard violated, a characterization of the shortcomings, e.g., diagnostic error, and if not apparent, why the act or omission creates a concern for the safety of patients. The patient should be referred to in a consistent anonymous fashion, e. g., "Patient Z1234."

(3) A charge should not contain two or more shortcomings, nor should it consist of simply a broad reference to, for example, "numerous medication errors". Similarly, one cannot collect evidence on six or seven charges and then add another broad charge, such as "and numerous other such failings" to the list of charges. Further, as stated above, the charge should not merely describe an act or omission; rather, while the act or omission can and should be described, the

charge must go further to state what standard was breached by the act or omission. For example, it is not sufficient to state that "On July 1, 1998 you reported wasting x amount of the controlled drug yz." The charge must then state what was wrong with that, such as "applicable administration rules require that such wasting be witnessed, but this was not done." The charge should also contain a characterization, and a reference to concern for patient safety, if necessary. For example, "This constituted a failure in the administration of controlled substances and raises serious concern that you cannot be trusted in administering controlled substances."

Characterizing the type of shortcoming helps the licensed health care provider understand how the VA views the provider's actions. The professional's response could easily be different depending in the characterization. For example, if VA characterized the above report of unobserved wasting differently, such as a missing controlled substance situation or as "diversion of controlled substance for personal use," the response to this graver charge could be significantly different than if the professional understood the charge only as an administrative failure. Do not leave the licensed health care practitioner in doubt about what was wrong with the act or omission when drafting the charge.

(4) Another example: "You saw patient Mr. X3456 on July 3, 1998. On that visit the patient complained of a sore throat, inability to swallow and significant weight loss. You failed to order indicated tests and procedures to diagnose Mr. X's cancer of the throat." This constituted diagnostic and treatment error." In this example, the circumstances of the charge are described specifically, including the date and an anonymous patient identifier, and they are confined to the facts necessary to the specific act or omission for which reporting is being considered. The example also states that a standard existed and was breached. Finally, the act or omission is characterized as to the general type of shortcoming, e.g., diagnostic failure, treatment failure. A basis for a concern about patient harm is apparent.

(5) Every charge must identify a specific shortcoming and be supported by relevant evidence. A charge of diversion for personal use often is difficult to support without an eye witness of the diversion and the personal use. Evidence of diversion but not of use should result in a charge only of diversion; that is serious enough.

(6) It is noted that in a drug administration or documentation case, it may be unnecessary to charge the professional with, and provide evidence on, a very large number of drug administration or documentation failures. If the failures are all of one type, e.g., failure to properly document, a representative number of relatively recent shortcomings can provide a sufficient basis to meet the reporting standard. For example, several failings of the same type over a reasonable period of time, especially when coupled with documented but unsuccessful remedial efforts, would ordinarily provide a sufficient basis for a Director to decide to report the professional for failure to properly administer or document drugs.

#### **b. Units of Evidence Supporting Charges**

(1) There should be a unit of evidence, that is a grouping of evidence, to support each charge. Each unit must demonstrate all of the following: the substandard event; the standard which should have been adhered to; the professional's knowledge of that standard if it is an unusual standard; an explanation of how the conduct or omission in question violated the standard, if not readily apparent; why the substandard care makes a reasonable person concerned for the safety

of patients. It should be noted that where a series of charges involve violation of the same standard, the standard need be set forth only in one unit of evidence. The units supporting the other similar charges need only refer to the standard set out in the earlier unit. Similarly, if an explanation of how the standard was breached or why the acts create concern for patients is the same as set forth in the earlier unit of evidence, subsequent units need only make a reference to the earlier unit.

(2) If a statement or record contains evidence supporting more than one charge, the statement or record ordinarily will be included in one unit of evidence only to the extent it supports that charge. Another portion of the statement or record, relevant to a different charge, will be included in the unit, supporting that charge, and so on. Alternatively, an entire statement or record can be included in each relevant unit, with the portion unrelated to that particular charge blanked out. If statements or documents have been compiled on some charges which ultimately do not appear appropriate for reporting, the portions of those records or statements which refer to such charges must be removed, blanked out or otherwise rendered illegible. Similarly, if evidence contains derogatory or personal information about the licensed health care professional which is not part of the charges being reported, that information should also be edited out or otherwise removed from the file.

#### **4. Resolution of Conflict in the Unit of Evidence**

In the process of collecting evidence to support a likely charge, the reviewer may encounter conflicting evidence. It is the responsibility of the reviewer to identify and exercise reasonable effort to resolve the conflict, and, to create a statement explaining the rationale of the reviewer in resolving the conflict. That statement should be included in the unit of evidence supporting the particular charge. For example, the licensed health care professional might deny, in a statement, being in the area of controlled substances on the night in question; however, two eyewitnesses might state that they saw that professional in that area at the relevant time. The reviewer must add a memo to the file identifying this conflict and resolving it, with rationale. In that instance the reviewer might believe, and therefore write, that she accepted the story of the two eyewitnesses because the professional's statement was self serving while she could find no reason why the two eyewitnesses would misstate the facts.

August 11, 1998

VHA HANDBOOK 1100.18  
APPENDIX C

**SAMPLE SPECIAL REPORTING PROCEDURES ALERT LETTER  
TO STATE LICENSING BOARDS**

*NOTE: For alerting a State board of a statistical association or egregious performance by occupational title.*

(Date)

(Address of SLB in the State where the professional is licensed)

Dear \_\_\_\_\_:

In compliance with Department of Veterans Affairs (VA) authority, be advised that a (occupational title of the employee), who (is/was) a licensed health care professional of this facility, has been (*INSERT EITHER (statistically linked with a series of unexpected patient events) OR (involved in egregious performance)*). (*Describe the unexpected events that are statistically linked to the professional OR describe the egregious performance*).

The VA initiates a report to SLB when there is substantial evidence that the professional failed to meet generally accepted standards of clinical practice so as to raise reasonable concern for the safety of patients. (*INSERT EITHER (Statistical association alone does not constitute substantial evidence since it fails to show what clinical standard was breached, how it was breached, when and where it was breached. Such association, however creates a duty to investigate further to determine whether the reporting standard has been met) or (The egregious performance described above is only a preliminary finding, based solely on limited evidence. Such information, however, creates a duty to investigate further to determine whether the reporting standard has been met.)*)

An accelerated review is being conducted to determine (*INSERT EITHER (if there is a non-statistical connection between the professional and the unexpected events) or (if the performance described above meets the reporting standard)*) Upon completion of the review, you will be advised whether substantial evidence does or does not exist to indicate that the professional breached a care standard which would raise reasonable concern for the safety of patients. If such evidence exists, the professional will be reported consistent with Privacy Act requirements to each SLB where the professional is licensed.

Notwithstanding the above, you may at any time request the professional's name and further information by submitting a letter consistent with subsection (b)(7) of the Privacy Act, Title 5 United States Code §552a (b) (7). Questions may be addressed to \_\_\_\_\_, (title), at (telephone number).

(Signature)

Medical Facility Director

August 11, 1998

VHA HANDBOOK 1100.18  
APPENDIX D

**SAMPLE ADVISEMENT NOTICE TO LICENSED HEALTH CARE PROFESSIONAL**  
(Certified Mail, Return Receipt Requested)

John Doe, M.D.  
123 East Main  
Little Town, Big State 00123

Dear Dr. Doe:

This is a notice to advise you that we are making a review of the concerns raised regarding your behavior or clinical practice, specifically [State in summary form the general concerns such as (your care and treatment of patient W1234), (your relationship with patient L2345), (your handling of controlled substances), (your physical or mental ability to meet the demands of your position), (your actions and conduct on June 27, 19XX), (your clinical judgment involving treatment of patient 3456)]. These concerns suggest that you may have so significantly failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients.

The Privacy Act requires that we attempt to collect information regarding these concerns to the greatest extent practicable directly from you. Our legal right to ask for information is Title 38 United States Code, Sections 501, 7401-7405 and their regulations. The information collected will be used to aid in making a determination whether to initiate a report to appropriate SLB, if there is substantial evidence that would support the above described concerns. Our review is intended to provide sufficient information to enable a full and fair decision in this matter. We will make the best decision possible on the basis of the information available to us, even if you decide not to provide any information. Any information you provide is voluntary and will be maintained in the Department of Veterans Affairs (VA) Privacy Act System of Records 77VA11, Health Care Provider Credentialing and Privileging Records -VA, which may be available to SLB, similar licensing bodies, or to other types of law enforcement authorities under the Privacy Act routine use authority. Any information you desire to provide regarding the concerns should be addressed to \_\_\_\_\_ at Department of Veterans Affairs Medical Center, 1234 Street, Anytown, Big State 12345 within 14 calendar days from your receipt of this notice, who may be reached at (123) 456-7899.

Should the review result in a tentative determination to make a report to appropriate SLB, you will be further advised and provided an opportunity to address what is proposed to be reported.

Sincerely yours,

Jane Smith  
Medical Center Director

**NOTE:** *The described concerns should be sufficient to enable the professional to understand what actions were involved and the nature of the concerns that have arisen from those actions.*

August 11, 1998

*One requirement is that the Advisement should be mailed Certified Mail, Return Receipt Requested should the professional no longer be employed by the facility initiating this review. Otherwise, if currently employed, the advisement may be hand delivered but the professional should sign a copy of the Advisement as an acknowledgment of receipt or there should be other evidence of receipt.*

## REPORTING AND RESPONDING TO STATE LICENSING BOARDS

1. **REASON FOR ISSUE:** This handbook is issued to provide Veterans Health Administration (VHA) procedures regarding reporting and responding to State Licensing Boards (SLB).
2. **SUMMARY OF CONTENTS/MAJOR CHANGES:** This policy expands VHA reporting requirements from separated licensed health care professionals only to include reporting of current licensed health care professionals and provides for alerts involving statistical associations and egregious conduct or performance.
3. **RELATED DIRECTIVE:** VHA Directive 1100, to be published.
4. **RESPONSIBLE OFFICE:** The Office of Patient Care Services (11B), is responsible for the contents of this VHA Handbook.
5. **DOCUMENTS RESCINDED:** VHA manual M-2, Part I, Chapter 34, is rescinded.
6. **RECERTIFICATION:** This document is scheduled for recertification on or before the last day of August 2003.

S/ Thomas Garthwaite, M.D. for  
Kenneth W. Kizer, M.D., M.P.H.  
Under Secretary for Health

Distribution: RPC: 0005  
FD

Printing Date: 8/98

**CONTENTS**

**REPORTING AND RESPONDING TO STATE LICENSING BOARDS**

PARAGRAPH	PAGE
1. Purpose .....	1
2. Authority .....	1
3. Background .....	2
4. Definitions .....	2
5. VA Initiated Reporting of Licensed Health Care Professionals to SLB.....	4
6. Five-Day Alert Notice and Expedited Review Procedure Required for Statistical Association and Egregious Performance Cases .....	5
7. Entering Agreements That Would Prohibit or Restrict Disclosure .....	6
8. Responsibility .....	6
9. The SLB Reporting Stages; Creating and Filing Related Records .....	6
10. The Initial Review Stage .....	7
11. The Comprehensive Review Stage .....	7
12. The Decision Stage .....	8
13. The Concurrence Stage .....	11
14. The Reporting Stage .....	12
15. Responding to Inquiries from SLB .....	13
16. Interim Response to SLB Inquiry when VA is Considering Reporting on its own Initiative .....	15

**APPENDIXES**

A Overview of the Five Stage State Licensing Board Reporting Process.....	A-1
B Guidelines for Compiling, Organizing and Preparing the State Licensing Board Reporting File.....	B-1
C Sample Special Reporting Procedures Alert Letter to State Licensing Board .....	C-1
D Sample Advisement Notice to Licensed Health Care Professional .....	D-1
E Sample Notice of Intent to Report Licensed Health Care Professional .....	E-1
F Sample Rebuttal Resolution Memorandum .....	F-1
G Sample Decision Memorandum From an Organizational Head Such as a VA Medical Center Director (00) to General Counsel (024).....	G-1
H Sample Reporting Letter to State Licensing Board .....	H-1
I Sample Privacy Act Subsection (b) (7) Letter From State Licensing Board (SLB) Requesting VA's SLB Reporting File.....	I-1

## REPORTING AND RESPONDING TO STATE LICENSING BOARDS

### 1. PURPOSE

It is the policy of the Department of Veterans Affairs (VA) to cooperate with State Licensing Boards (SLB) after VA initiates a report and whenever there is an inquiry from a SLB regarding a VA licensed health care professional, whenever possible. This Handbook sets forth policies and procedures to be carried out by Veterans Health Administration (VHA) for:

- a. Reporting licensed health care professionals to SLB as a VHA initiative;
- b. Responding to SLB in response to inquiries regarding VHA licensed health care professionals.

*NOTE: Requirements for reporting to the National Practitioner Data Bank (NPDB) are outlined in the VHA Handbook 1100.17.*

### 2. AUTHORITY

a. VA has broad authority to report to SLBs those employed or separated health care professionals whose behavior or clinical practice so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. The authority to report those professionals who meet the above standard is derived from VA's long-standing statutory authority, contained in Title 38 United States Code (U.S.C.) §§ 501, 7401-7405, which authorizes the Under Secretary for Health as head of the VHA to set the terms and conditions of initial appointment and continued employment of health care personnel as may be necessary for VHA to operate health care facilities. This authority includes requiring health care professionals to obtain and maintain a current license, registration, or certification in their health care field.

b. The Veterans' Administration Health-Care Amendments of 1985, Public Law 99-166, and Part B of Title IV of Public Law 99-660, the Health Care Quality Improvement Act of 1986 are both Acts which authorize and require VHA to strengthen quality assurance and reporting systems to promote better health care. Pursuant to Section 204 of Public Law 99-166 VA established a comprehensive quality assurance program for reporting any licensed health care professional to SLBs who:

- (1) Was fired or who resigned following the completion of a disciplinary action relating to such professional's clinical competence;
- (2) Resigned after having had such professional's clinical privileges restricted or revoked; or
- (3) Resigned after serious concerns about such professional's clinical competence had been raised but not resolved.

c. The statutory provisions of 38 U.S.C. §§501, 7401-7405, augmented by Public Laws 99-166 and 99-660, provide VHA ample authority to make reports to SLBs when exercised consistent with Privacy Act requirements for release of information.

### 3. BACKGROUND

a. VA is responsible for assuring that its patients receive appropriate and safe health care. Similarly, VA has an obligation to reasonably assure that its health care staff meet or exceed generally accepted professional standards for patient care and as such has the obligation to alert those entities charged with licensing health care professionals when there is serious concern with regard to a licensed health care professional's clinical practice. This obligation includes notifying SLBs of VA's concern with regard to the clinical practice of current or former professionals and responding to inquiries from SLB concerning the clinical practice of those professionals.

b. VA has a responsibility to protect the privacy rights of its current and former professionals in the reporting process. VA will ensure such protection by conforming to the disclosure requirements of Federal information law, including the Privacy Act, when initiating disclosure or responding to inquiries from SLB. However, the guiding principle will be to make patient safety the paramount consideration.

c. The rationale for reporting professionals under the continuing jurisdiction and supervisory control of VA, for deficiencies which might impact on the safety of patients in a board's jurisdiction, is as follows:

(1) Many licensed health care professionals who provide health care services to VA beneficiaries are not exclusively under the control of VA. These professionals may provide health care services to patients, other than VA beneficiaries, elsewhere under a board's jurisdiction. These professionals include part-time, intermittent, on and off-station fee basis and full-time professionals who may be involved in health care activities outside their full-time VA employment.

(2) VA must avoid even the appearance of "sheltering" or "protecting" its professionals from reasonable reporting standards which apply in the non-VA health care community.

### 4. DEFINITIONS

a. **Generally Accepted Standards of Clinical Practice.** Generally accepted standards of clinical practice is the level of ability and practice expected of competent professionals, as well as the moral and ethical behavior necessary to carry out those responsibilities.

b. **Reasonable Concern for the Safety of Patients.** Reasonable concern for the safety of patients is when, given all the circumstances, a reasonable person would be concerned for the safety of patients treated by the licensed health care professional.

c. **Licensed Health Care Professional.** A licensed health care professional is an individual appointed or utilized under Title 5 U.S.C. or Title 38 U.S.C. on a full-time, part-time, intermittent, off-station or on-station, fee basis; contract basis, or sharing agreement

basis; either permanent or temporary, whether paid or without compensation, who is licensed, certified or registered in a health care profession (such as a physician, dentist, podiatrist, optometrist, nurse, physician assistant, expanded-function dental auxiliary, physical therapist, practical or vocational nurse, pharmacist, social worker occupational therapist, or certified or registered respiratory therapist). It includes licensed residents, consultants and attendings. As used in this Handbook, the term "licensed health care professional" also refers to a licensed health care provider appointed to a position in an occupation where appointment in VA does not require licensure or certification (such as a speech pathologist, psychologist, dietitian, or audiologist). As used in this Handbook, it also refers to licensed individuals working outside their licensed occupation, such as a registered nurse appointed to a Title 5, U.S.C. position, in any organizational unit or section of VHA including Network offices and Headquarters.

d. **Licensure**. Licensure is the official or legal permission to practice in an occupation, as evidenced by documentation issued by a State in the form of a license and/or registration.

e. **Certification**. Certification is the documentation issued by a recognized health care organization or other established entity such as a State attesting to minimum competence in a health care field.

f. **Separated Licensed Health Care Professional**. A separated licensed health care professional is any licensed health care professional no longer on VA rolls and who left VA for any reason. This includes both voluntary and involuntary reasons, including disability retirement.

g. **Currently Employed Licensed Health Care Professional**. A currently employed licensed health care professional is any licensed health care professional who is on VA rolls for the provision of health care services, regardless of the status of the professional, such as full-time, part-time, contract service, fee-basis, or without compensation.

#### h. **Substantial Evidence**

(1) Substantial evidence is the degree of relevant evidence that would permit a reasonable person to conclude that there is a solid, material basis for believing that the professional engaged in a substandard act which created a reasonable concern for patient safety.

(2) Substantial evidence of wrongdoing is more than a mere suspicion, or uncorroborated hearsay or rumor.

(3) For SLB reporting purposes, this definition focuses more on the quality and believability of the evidence than the quantity of the evidence. Substantial evidence of wrongdoing can be present, however, even if all the evidence, taken together, would lead a reasonable person to conclude that, more likely than not, no wrongdoing occurred.

## 5. VA INITIATED REPORTING OF HEALTH CARE PROFESSIONALS TO SLB

a. VHA facilities (and other components) will report on their own initiative (after concurrence from General Counsel) each licensed health care professional whose behavior or clinical practice so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients.

b. This policy applies to all VHA professionals at all levels and organizational units whether or not the conduct is directly related to the provision of VA health care, and whether or not the conduct occurred while in a duty status. The report will be submitted to each SLB where the professional holds a license. The following are examples of substandard actions which would ordinarily provide a reasonable basis for a concern for the safety of patients, and thus would be reported:

(1) Significant deficiencies in clinical practice, for example: lack of diagnostic or treatment capability; multiple errors in transcribing, administering or documenting medications; inability to perform clinical procedures considered basic to the performance of one's occupation; or performing procedures not included in one's clinical privileges in other than emergency situations.

(2) Patient neglect or abandonment.

(3) Mental health impairment sufficient to cause the individual to make judgment errors affecting patient safety, to behave inappropriately in the patient care environment, or to provide unsafe patient care.

(4) Physical health impairment sufficient to cause the individual to provide unsafe patient care.

(5) Substance abuse when it affects the individual's ability to perform appropriately as a health care provider or in the patient care environment.

(6) Falsification of credentials.

(7) Falsification of medical records or prescriptions.

(8) Theft of drugs.

(9) Inappropriate dispensing of drugs.

(10) Unethical behavior or moral turpitude (such as sexual misconduct toward any patient involved in VA health care).

(11) Patient abuse, including mental, physical, sexual, and verbal abuse, and including any action or behavior that conflicts with a patient's rights identified in Title 38, Code of Federal Regulations (CFR); intentional omission of care; willful violations of a patient's privacy; willful physical injury, or intimidation, harassment or ridicule of a patient.



(12) Falsification of research findings, regardless of where the research was carried out or the funding source as long as involved in some aspect of operations of the VA.

c. When a decision is reached to initiate a SLB reporting regarding a currently employed professional, a decision may also be made to initiate appropriate disciplinary proceedings or to place the professional in a non-clinical environment. However, reporting to a SLB is to proceed on its own time schedule and independent of the time requirements of any other proceedings to avoid unacceptable delays which might otherwise occur. It is noted that disciplinary actions are based on a preponderance of evidence process; in contrast, reporting to SLBs requires only a finding that there is substantial evidence that the reporting test was met.

d. A VA initiated report to a SLB (after General Counsel concurrence) is only notice to a Board that there is a question of a professional's clinical practice or behavior. Reporting is not a VA action against a professional's license. The Board may or may not, according to its standards, follow-up and obtain relevant portions of the VA SLB Reporting File, or, ultimately, undertake formal proceedings against the license of the professional.

e. In the event there has been a court conviction, the public documents related to that conviction may be provided directly to appropriate SLB by the responsible organizational head without further review.

## **6. FIVE DAY ALERT NOTICE AND EXPEDITED REVIEW PROCEDURE REQUIRED FOR STATISTICAL ASSOCIATION AND EGREGIOUS PERFORMANCE CASES**

a. Special procedures are required when a statistically significant association links a licensed health care professional to a series of unexpected events that have resulted in patient injuries or deaths or when egregious performance by a licensed health care professional is found.

(1) Statistical significance is established at the .05 level of confidence, using generally accepted statistical methods.

(2) Egregious performance is defined as conduct by a licensed health care professional that causes the facility Director, or designee, to summarily remove the professional from clinical duties because of an immediate and urgent concern for the safety of patients.

b. When a determination is made of either a statistical association or egregious performance, two immediate actions are required.

(1) The facility Director will commence a SLB Reporting Program review, as outlined in this Handbook, on an expedited basis.

(2) Within 5 days of the determination, the facility Director will provide to each SLB where the professional is licensed an alert of the statistical association or the egregious performance concurrently providing a copy of the alert to the Veterans Integrated Service Network (VISN) (10N\_\_\_), the Chief Network Officer (CNO) (10NC), the Office of the Medical Inspector (10MI), and the General Counsel (02).

c. The alert will be prepared in the same format as shown in the Sample Special Reporting Procedures Alert Letter to SLB in Appendix C. It will:

- (1) Identify only the occupational title of the professional such as Physician, Nurse, or Pharmacist;
- (2) Describe either the unexpected events that are statistically linked to that professional or the egregious performance;
- (3) Disclose that an expedited review is being conducted to determine if there is a non-statistical nexus between the professional and the unexpected events in a statistical case or to develop additional information in an egregious performance case;
- (4) Notify the Board that upon completion of the review, it will be advised of whether substantial evidence does or does not exist to indicate that the professional failed to meet generally accepted standards of clinical practice that have caused the concern for patient safety; and
- (5) Assure the Board that while the professional will be reported by name consistent with Privacy Act requirements to each SLB(s) where the professional is licensed if substantial evidence exists to establish a statistical linkage or substandard performance, it may nevertheless at any time during the review, obtain the name of the licensed professional and further information, by making a request consistent with subsection (b)(7) of the Privacy Act (see App. I for sample request letter). This provision is an exception to the paragraph of this Handbook entitled, "Interim Response to a SLB Inquiry When VA is Considering Reporting on Its Own Initiative." Any information disclosed under a (b)(7) request that identifies a specific professional will also be provided to that professional.

## **7. ENTERING AGREEMENTS THAT WOULD PROHIBIT OR RESTRICT DISCLOSURE**

VA Directors, heads and other employees are not authorized to and will not enter into any formal or implied agreement that would prohibit or interfere with the reporting of a licensed health care professional to a SLB, or destroy or remove any information needed in the reviewing process, in return for a personnel action such as resignation, retirement, or reassignment. Any such purported agreement is not binding upon the VA and such an agreement forms the basis for administrative and/or disciplinary action.

## **8. RESPONSIBILITY**

The head of each organizational component of VHA has overall responsibility for VA initiated reporting to SLB and responding to inquiries from SLB. For example, Network Directors are responsible at the network level and facility Directors at the facility level.

## **9. THE SLB REPORTING STAGES; CREATING AND FILING RELATED RECORDS**

- a. SLB Reporting Program involves five stages:

- (1) The Initial Review Stage;
  - (2) The Comprehensive Review Stage;
  - (3) The Decision Stage;
  - (4) The Concurrence Stage; and
  - (5) The Reporting Stage. *NOTE: These five stages will normally be completed in about 100 days. An overview of the tasks, records to be created and procedures is provided in Appendix A with suggested timeframes.*
- b. Guidelines for compiling and organizing the SLB reporting file are contained in Appendix B.
- c. The records created or compiled in connection with this reporting, including any Stage, are to be filed and retrieved by the name of the licensed health care professional and are to be maintained in Privacy Act System of Records 77VA11, Health Care Provider Credentialing and Privileging Records –VA, regardless of whether the professional has a credentialing folder.

## 10. THE INITIAL REVIEW STAGE

The Director or head will ensure that within 7 calendar days of the date a licensed health care professional leaves VA employment, or, information is received suggesting that a current employee's clinical practice has met the reporting standard, an initial review of the individual's clinical practice is conducted to determine if there may be substantial evidence that: the individual so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. Usually this review will be conducted and documented by first and second level supervisory officials. There must be reasonably detailed documentation that this review was performed. *NOTE: When the initial review indicates that a professional has retired for disability reasons, a comprehensive review is always required and reporting of that professional is usually indicated.*

## 11. THE COMPREHENSIVE REVIEW STAGE

a. **Failure to Meet Accepted Standards.** When the initial review suggests that there may be substantial evidence that the licensed health care professional so failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients, the Director, or head of the organizational component, is responsible for immediately initiating a comprehensive review to determine whether there is, in fact, substantial evidence that this reporting standard has been met. This involves the preparation of a SLB Reporting File. The objective of the comprehensive review is to present a balanced and complete picture in the file of the circumstances which formed the basis for the concern. Consistent with information law requirements, the Director or head will ensure that the reviewer advises the licensed health care professional, as soon into the comprehensive review as is practicable, of the purpose of the review and invite the professional to provide information. The information conveyed to the professional will include the information contained in the sample Advisement Notice to the

Licensed Health Care Professional in Appendix D. If the Advisement Notice is sent by mail rather than delivered in person, Certified Mail, Return Receipt Requested will be used. The notification procedures set forth below will be followed in providing the Advisement Notice.

b. **Conflicting Evidence.** The reviewer should also be advised to identify in the review any significant conflicting evidence, make reasonable effort to decide what the more believable conflicting evidence seems to be, and set out in the review, the rationale for believing one position over another. The comprehensive review may or may not conclude that there is substantial evidence that: (1) there was substandard care; and (2) that some or all of the substandard care creates a reasonable concern for the safety of patients regarding each concern. Whenever, prior to the sending of the Notice of Intent to Report, evidence is gathered but determined not to be substantial evidence that would support a charge in the Notice of Intent to Report, that evidence shall be preserved and marked "Review Material – Not Substantial Evidence" and maintained as marked in 77VA11 under the professional's name.

c. **SLB Reporting File.** The SLB Reporting File consists of three parts: Evidence File, Notice of Intent to Report, and the Response and Rebuttal Resolution Memorandum. The Evidence File will be prepared as required by this Handbook. All parts of the file will be compiled and organized in accordance with the instructions set forth in the Guidelines for Compiling and Organizing the SLB Reporting File in Appendix B.

d. **Notice of Intent to Report.** When the Evidence File indicates that there is substantial evidence that the reporting standard has been met, a Notice of Intent to Report will be provided by the reviewer to the licensed health care professional. A notice assists in satisfying information law requirements that reasonable efforts be made to ensure that the Evidence File information is timely, accurate, relevant and complete. Each licensed health care professional being considered for reporting to SLB will be provided a notice or at least a reasonable attempt to provide a notice is to be made. The notice must list each charge, and provide a brief but reasonably detailed description of the facts giving rise to each charge. The description must be sufficiently clear and precise so that the professional can understand exactly what circumstances are giving rise to each charge and what the exact wrongdoing was. A charge not contained in the notice may not be disclosed to SLB. Accordingly, the Index of Charges from the Evidence File will be copied verbatim into the Notice of Intent to Report, except for tab page references, and patient identifiers, which must not be included. The content of the Notice of Intent to Report must conform to the sample Notice of Intent to Report letter contained in Appendix E to meet information law requirements.

e. **First Notice of Intent to Report.** The Notice of Intent to Report requirement is satisfied by the use of a Certified Mail, Return Receipt Requested letter. A memorandum or other alternative notification method is acceptable, however, if all of the information contained in the sample Notice of Intent to Report letter, Appendix E, is included in writing to the professional who acknowledges receipt or there is other proof of receipt. Proof of notice such as a signed Certified Mail Return Receipt or a witness statement, will be added to the SLB Reporting File in the location indicated in the Guidelines in Appendix B.

f. **Second Notice of Intent to Report.** A second Notice of Intent to Report will be sent, Certified Mail, Return Receipt Requested, should there be no written acknowledgment from the professional of the Notice of Intent to Report certified mail letter and the notice was not

returned within 15 days of the mailing date. Reasonable effort must be made to determine the correct current address of the licensed health care professional if it is unknown or if there is a question before sending a second notice. This would include contacting SLB, professional organizations, and developing other leads that could perhaps include prospective employers and references. If the second Notice of Intent to Report is unsuccessful the reviewer shall proceed after documenting in the file, the efforts to provide notice.

g. **Licensed Health Care Professional Request for Evidence File.** Should the professional ask for the evidence being used to make the determination, the evidence will be provided in a manner to insure receipt and acknowledgment of delivery, such as by Certified Mail, Return Receipt Requested, using a consistent anonymous patient identification after patient identifiers have been redacted. The professional will have an additional 14 days from the date of receipt to respond and should be so advised.

h. **Response of the Professional and Rebuttal Resolution Memorandum.** Whenever a licensed health care professional responds to and contests any of the charges, the reviewer must consider each contested, or rebutted, charge and address each in a Rebuttal Resolution Memorandum similar in format to the sample Rebuttal Resolution Memorandum in Appendix F. The reviewer must consider the evidence on both sides of a contested point and make a decision on which to believe. Making this determination may involve obtaining additional evidence. It always requires at least an explanation as to how the reviewer has resolved the conflict. The resolution might, for example, involve believing one person's word over another's; where that is the case, a short explanation of why one over another was believed should be entered in the Memorandum. For another example, if physical abuse is the charge, and the professional responded that the patient provoked the situation by striking first, the Memorandum would address this argument by stating the employee's rebuttal point and resolving it with a statement to the effect that there is no acceptable reason to strike a patient. It is possible that a professional's response will demonstrate that a particular charge is unfounded; in that case, the charge and the supporting evidence must be deleted from the Evidence File, Notice of Intent to Report, the Response and wherever else they may appear in the SLB Reporting File before it is forwarded for concurrence. In such instances, that evidence shall be preserved and marked "Notice to Report – Not Substantial Evidence" and maintained as marked in 77VA11 under the professional's name. The Response and Rebuttal Resolution Memorandum material will be added to the SLB Reporting File at the point indicated in the Guidelines in Appendix B. For some additional guidance see the discussion of Resolution of Conflict in the Unit of Evidence in the Guidelines in Appendix B.

*NOTE: It is the intent of this policy to make determinations based on all information reasonably and timely available. However, strict adherence to time limits must not be utilized to defeat this process. Thus, it is expected that the VA would consider a late reply to a Notice of Intent to Report notice letter. Similarly, late action by VA would not be a bar to further processing or to reporting.*

## 12. THE DECISION STAGE

a. Upon completion of the Comprehensive Review Stage, the Director or head will decide whether to report the licensed health care professional. The entire Evidence File, Notice of

Intent to Report documentation, and any Response and Rebuttal Resolution Memorandum materials, will be considered in determining whether there is substantial evidence that, as to each charge in question, the professional so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. The determination ordinarily should be made within 7 calendar days after the Response segment of the Comprehensive Review has been completed.

b. It should be noted that not infrequently three or four charges, taken together, may result in a sufficient basis to warrant reporting. On occasion, during the Comprehensive Review process, some or even all of the charges may be dropped. Where some, but not all, of the charges are dropped the remaining charges may or may not be sufficient to warrant reporting.

c. The Director or head may wish to consult with and consider recommendations from appropriate clinical service chiefs as to whether the reporting standard has been met for each of the charges. When a decision is made not to report a professional, the file should be appropriately noted and the professional so advised.

d. When the Director or head decides to report the licensed health care professional, that official will add a Decision Memorandum to the file following the format of the sample Decision Memorandum in Appendix G. The Decision Memorandum will be addressed to the General Counsel (024), through the CNO (10NC). (*NOTE: Do not submit the SLB reporting file directly to General Counsel.*) and will contain the following information:

(1) A statement that the Director or head has made a decision based upon consideration of the entire SLB Reporting File to report a licensed health care professional, providing the name and professional title (M.D., R.N., ) of the individual, and the SLB to whom the report will be made;

(2) The intended reporting statement. Note that in accordance with Congressional intent to maintain appropriate confidentiality for the professional, the statement is to be limited to a generic description of the clinical shortcomings involved, such as Dr. Fictitious W. Jones so failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients when he repeatedly erred in the selection of appropriate medications;

(3) A statement that all portions of the SLB Reporting File have been compiled and organized as required in this Handbook and Appendix B, and in particular: the Advisement Notice procedure, the Notice of Intent to Report procedure, and the Rebuttal Resolution Memorandum procedure have been met and at what tab or page number in the file that documentation can be found.

(4) Confirmation that the SLB Reporting File is maintained in VA's Privacy Act System of Records 77VA11, Health Care Provider Credentialing and Privileging Records -VA, and this disclosure is authorized under the SLB routine use contained in that system;

(5) A statement indicating that all unsubstantiated or irrelevant information has been removed from the File. To enable review, only the records proposed to be disclosed should be submitted. Redactions or withholdings should include charges and related information for

which substantial evidence was lacking, harmful or personal information irrelevant to the sustained charges, and personal identifiers of patients.

(6) Any narrative or other material considered desirable to clarify, draw attention to or otherwise augment the SLB Reporting File.

(7) A statement indicating that a copy of the File, as proposed to be provided to the SLB and in an unredacted fashion, will be maintained.

(8) A request for general review by the CNO (10NC) and legal review by General Counsel (024) of the File, Decision Memorandum, and concurrence or comments based on the review.

### 13. THE CONCURRENCE STAGE

a. Within 5 calendar days of deciding to report, the Director or head shall forward to the General Counsel (024) for information law review through the CNO (10NC) for general review, the entire SLB Reporting File, i.e., consisting of the Evidence File, Notice of Intent to Report documents, any Response and Rebuttal Resolution Memorandum materials, and the Decision Memorandum. It is anticipated that once a complete file is received by the General Counsel (024), the time required for the legal review will not exceed 30 calendar days.

b. The CNO upon receiving the SLB Report will, within 5 calendar days of receipt, review the package to assure that:

(1) The Decision Memorandum conforms to the requirements of this Handbook;

(2) The Evidence File contains: an Advisement Notice; Index of Charges; evidence set off in a separate unit of evidence for each charge and organized in order corresponding to the Index; adequate documentary support for each charge, including information regarding standards breached, harm to patients and resolution of any conflicting evidence;

(3) The Notice of Intent to Report document is present in the correct form and location in the File;

(4) Any Response and Rebuttal Resolution Memorandum materials are included, in the correct location in the File; and

(5) Information inappropriate for consideration is NOT included; for example, such things as 38 U. S. C. 5705 protected quality assurance information, and information gathered but insufficient to support a charge in the Notice of Intent to Report.

c. Reports that do not conform to the requirements of this policy may be held by the CNO for additional information or returned to the facility for revision and resubmission. If it is determined that the evidence is complete and that it does not demonstrate that the individual so substantially failed to meet generally accepted standards as to raise reasonable concern

for the safety of patients, the file will be returned to the facility without forwarding to General Counsel for legal review.

d. The General Counsel (024) will review the SLB Reporting File and Decision Memorandum and evaluate whether:

- (1) There is disclosure authority for making the report;
- (2) There has been the required effort to assure reasonable accuracy in the File as shown by a properly organized Evidence File, and, by issuance of the Advisement Notice, the Notice of Intent to Report and the materials in the Response and Rebuttal Resolution Memorandum Section of the File; and
- (3) There is substantial evidence to make the intended report; or
- (4) There is additional information needed (that will be requested directly from the submitting facility) to determine whether the intended reporting would be permitted by applicable information law provisions.

e. The General Counsel (024), upon completion of its review, will return the complete SLB Reporting File to the CNO (10NC) with its memorandum concurring or objecting to the proposed reporting based upon information law requirements and the materials reviewed. Should the General Counsel memorandum concur in whole or in part with the proposed disclosure, it is anticipated that there may be recommendations consistent with confidentiality and reporting considerations, as to what information to report initially to the SLB and what information to subsequently disclose should the SLB request follow-up information. The CNO will return the SLB reporting file to the originator with a cover memorandum authorizing or denying authority to report to the SLB.

#### 14. THE REPORTING STAGE

The Director or head will send a reporting letter (sample in App. H) to relevant SLB within 7 calendar days of receipt of a concurring legal review memorandum opinion from the General Counsel via the CNO following the format of the sample Reporting Letter to SLB in Appendix H. The letter to be released to the appropriate SLB should be limited, consisting only of the name and medical title of the professional and a generic description of the charges being reported, and be consistent with any guidance contained in the General Counsel memorandum. It should state what the SLB must do to obtain detailed information on the matter. A copy of the letter submitted to the SLB will be sent to the CNO (10NC), the Office of the Medical Inspector in VHA Headquarters and the professional. A letter from the SLB requesting follow-up information received by the facility must meet the Privacy Act, 5 U. S. C. § 552a, requirements identified in this Handbook to permit disclosure of the relevant portions of the SLB Reporting File (a sample request letter from a board is provided in App. I). All information to be released to the SLB will be released only after patient identifiers have been deleted by redaction and replaced with consistent anonymous patient identifiers.



**Department of  
Veterans Affairs**

**(10A2)**

Washington DC 20420

OFFICIAL BUSINESS

Penalty for private use \$300

**Ms. Elaine Kaplan  
U.S. Office of Special Counsel  
1730 M Street, NW  
Suite 300  
Washington, DC 20036-4505**