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The Special Counsel

December 16, 2002

The President
The White House
Washington, DC 20500

Re: OSC File No. DI-02-0308

Dear Mr. President:

In accordance with 5 U.S.C. § 1213(e)(3), I am transmitting a report provided to me pursuant to 5 U.S.C. § 1213(c) and (d) by the Honorable Anthony J. Principi, Secretary of Veterans Affairs. The report sets forth the findings and conclusions of the Secretary upon investigation of disclosures of information allegedly evidencing a substantial and specific danger to public health and safety arising out of actions by employees at the Department of Veterans Affairs (VA), Veterans Health Administration, Eugene J. Towbin Healthcare Center, North Little Rock, Arkansas.

The whistleblower, Bonnie Gill, Licensed Practical Nurse (LPN), consented to the release of her name. Ms. Gill declined to provide comments on the agency report to this office pursuant to 5 U.S.C. § 1213(e)(1).

Ms. Gill's allegations were transmitted to the Secretary of Veterans Affairs for investigation on March 15, 2002. Secretary Principi referred the matter to the Central Arkansas Veterans Healthcare System in Little Rock, Arkansas, and the facility convened an Administrative Board of Investigation. Secretary Principi sent a report to this office on July 17, 2002.

We have carefully examined the original disclosures and reviewed the agency's response. Pursuant to 5 U.S.C. § 1213(e)(2), I have determined that the findings in the agency report--which largely substantiated the whistleblower's allegations--appear reasonable. However, the agency report does not contain all of the information required by statute. Specifically, as discussed in more detail below, I find that the agency failed to satisfy the requirements of 5 U.S.C. § 1213(d)(5)(C) by omitting from the agency report the names of the subject officials against whom disciplinary action was taken.

The Whistleblower's Disclosures

Bonnie Gill, LPN, has worked at the Eugene J. Towbin Healthcare Center for three years, and as an LPN for a total of six years. Ms. Gill works in the extended care unit of the healthcare center, which is located on Floor 1-C. She alleged that two supervisory nurses in the extended care unit engage in inappropriate behavior that endangers the health and safety of patients.

Ms. Gill alleged that Mary Bahan, Charge Nurse, often abused patients verbally, addressing them in a raised voice, with a harsh tone. For example, Ms. Gill stated that Ms. Bahan frequently yelled at an overweight patient in the unit and accused him of laziness. She also reported that she witnessed Ms. Bahan humiliate another patient by declaring to several other nurses, in the patient's presence, "The only reason why he wants to get into the whirlpool is because he wants to masturbate."

As another example of Ms. Bahan's abusive behavior, Ms. Gill alleged that Ms. Bahan purposefully deprived one patient of dinner on several occasions. Ms. Gill explained that this patient often preferred to eat in his room rather than the dining hall because it was strenuous for him to get in and out of bed, as he used a geri-chair. She stated that, on more than one occasion when this patient decided to eat in his room, Ms. Bahan accused him of laziness and told him that, unless he got out of bed and went to the dining hall, he would not be allowed to eat dinner. She then forbade the other nurses in the unit from bringing him food. Ms. Gill explained that hospital policy allows patients to decide for themselves whether they would prefer to eat in the dining hall or have their food brought to them in their room.

Ms. Gill also contended that Ms. Bahan often ignored the patients' personal needs. For example, she stated that, on more than one occasion, she discovered a patient lying in a soiled bed, crying hysterically. This patient told Ms. Gill that she had informed Ms. Bahan that she needed to go to the bathroom beforehand, but Ms. Bahan failed to assist her or to notify one of the other nurses about the situation. Ms. Gill stated that this patient had full control over her bodily functions at the time, and only soiled the bed when she was unable to wait any longer for assistance.

In addition, Ms. Gill alleged that, on several occasions, Ms. Bahan failed to report patient accidents and falls, although doing so was mandatory. She stated that often when Ms. Bahan witnessed a patient fall, she commented to the other nurses present, "I did not see him fall, did you?" She then neglected to file an incident report or notify the Nurse on Duty. Ms. Gill saw this occur with several different patients, including three or more times with one patient in particular. According to Ms. Gill, properly reporting an accident ensures that a

patient will be thoroughly examined for possible injury. Thus, Ms. Bahan's failure to report accidents may have resulted in patients' injuries going undetected and untreated.

Ms. Gill also alleged wrongdoing on the part of her second-line supervisor, Kathryn Morris, Nurse Manager. Ms. Gill asserted that, on at least three occasions, Ms. Morris interrupted her while she was performing a medication pass, i.e. while she was distributing medication to patients, in order to discuss a non-urgent administrative matter. Ms. Gill explained that, in the nursing profession, it is generally understood that medication passes should never be interrupted, except in the event of an emergency. Ms. Gill stated that, each time this occurred, she vehemently objected to pausing the medication pass, but Ms. Morris insisted. In spite of Ms. Gill's protestations, Ms. Morris detained her for approximately one hour on April 12, 2001, for approximately 30 minutes on March 29, 2001, and for a similar length of time on at least one other occasion for which she does not recall the exact date. She alleged that, as a result of the delay, patients did not receive their medications at the prescribed time, including diabetic patients requiring time-sensitive doses of insulin.

Ms. Gill contended that these and other actions by Ms. Bahan and Ms. Morris demonstrated a pattern of mistreatment and neglect that was detrimental to the mental, emotional, and physical health of the patients in the extended care unit.

The Department of Veterans Affairs Investigation and Report

Ms. Gill's allegations were investigated by an Administrative Board of Investigation (Administrative Board), comprised of a Clinical Psychologist from the Mental Health Service (who served as the Chairman), an Administrative Officer from the Environmental Management Service, and an LPN from the Nursing Service. The Administrative Board heard testimony from the Associate Chief Nurse for Extended Care, the Assistant Nurse Manager of the unit, 14 current unit employees, 3 former unit employees, and one patient on the unit. In addition, the subject officials, identified in the agency report as "Charge Nurse" and "Nurse Manager," also testified. Based on the witnesses' testimony, the Administrative Board found Ms. Gill's allegations to be substantiated.

According to the agency report, nine current employees and two former employees testified that the Charge Nurse's behavior towards patients was abusive. An extended care patient testified that the Charge Nurse yelled at him and other patients and used harsh language when speaking to them. The agency report notes that the witnesses used the following terms to describe her behavior: "yelling," "scolding," "demanding," "hateful," and "disrespectful."

Regarding the Charge Nurse's alleged mistreatment of extended care patients, three employees testified that she failed to follow VA policy and procedures governing the reporting of patient accidents and falls. An extended care patient testified that the Charge Nurse had forced him to get out of bed to eat. His testimony was corroborated by an employee who witnessed

the incident. In addition, five current employees testified that the Charge Nurse had similarly forced two other patients either to shower or to get out of bed to eat.

The witnesses also provided testimony to the Administrative Board indicating that the Charge Nurse exhibited inadequate nursing skills and poor work habits. Specifically, six current 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 refused to draw blood; and seven current employees and one former employee testified that she refused to change the dressing on patients' wounds. Lastly, seven current employees and two former employees testified that much of her time at work was spent reading novels rather than attending to patient care.

Based on the foregoing testimony, the Administrative Board concluded that (1) the Charge Nurse verbally abused and mistreated patients; (2) her nursing skills were below the acceptable standard of care; (3) she was willfully idle on the job; and (4) she failed to follow VA policy and procedures for reporting patient falls.

The Administrative Board also heard testimony regarding inappropriate behavior by the Nurse Manager. Four current employees and one former employee corroborated Ms. Gill's allegation that the Nurse Manager sometimes interrupted their patient care duties to discuss routine administrative matters. These witnesses testified that this behavior was inappropriate and negatively impacted patient care. In addition, the Associate Chief Nurse for Extended Care agreed that such interruptions should be avoided.

Although the Nurse Manager's job duties did not allow her much opportunity to interact with patients directly, the witnesses offered testimony showing that she often mistreated patients during her limited contact with them. Five current employees and one former employee testified that her behavior toward patients was "abusive." An extended care patient testified that the Nurse Manager displayed a poor bedside manner, talked down to him, and would leave the room before he finished speaking to her. The patient and one staff member testified that the Nurse Manager sometimes consumed patients' snacks and drinks without permission. In addition, three staff members testified that the Nurse Manager had witnessed the Charge Nurse verbally abuse patients, yet she failed to take any action in response. According to the agency report, the witnesses used the following terms to describe the Nurse Manager's behavior toward patients: "yelling," "scolding," "hateful," "harsh," "blunt," "mean," and "not compassionate."

The witnesses also criticized the Nurse Manager's managerial skills. Seven employees testified that she failed to address a staffing shortage in the unit. Seven employees testified that she sometimes changed employees' schedules or work assignments without notifying them in advance. Six employees testified that the Nurse Manager made little effort to accommodate their leave requests. Two current and two former employees complained about the manner in

which she responded to their requests for light duty work. Five employees complained that the Nurse Manager held staff meetings infrequently, and seven employees complained that the unit had no educational program.

Several employees provided testimony concerning the Nurse Manager's "negative staff interactions." Both current and former staff members testified that the Nurse Manager failed to treat employees equally; for example, they asserted that she exhibited favoritism in scheduling and work assignments. In this regard, the Assistant Nurse Manager testified that the Nurse Manager had ignored concerns she expressed about the Charge Nurse. Some staff members testified that the Nurse Manager punished employees who voiced complaints by assigning them heavier duties. Six employees testified that she failed to advise them of their right to union representation during counseling.

Based on the foregoing, the Administrative Board concluded that the Nurse Manager had (1) inappropriately interrupted patient care, (2) verbally abused patients, (3) taken food items from patients without their permission, (4) failed to report the abusive behavior of the Charge Nurse, (5) engaged in negative interactions with her subordinates, (6) violated agency policies and procedures governing the assignment of light duty work to sick or disabled employees, and (7) retaliated against employees who complained by mishandling their schedule and leave requests. Lastly, the Administrative Board found that the unit's educational needs were not adequately met and staff meetings were held infrequently.

The agency report includes a description of actions taken or planned in response to the findings of the Administrative Board of Investigation as well as the findings of a parallel investigation, examining many of the same allegations, conducted by the VA Office of the Inspector General.² These actions are outlined below:

- (1) The Chief, Nursing Service, proposed termination for the Nurse Manager on May 24, 2002, and the Charge Nurse on May 28, 2002. Subsequently, the Charge Nurse resigned, effective June 5, 2002, and the Nurse Manager resigned, effective July 12, 2002.
- (2) The facility initiated procedures to report the Charge Nurse and Nurse Manager to the State Licensing Boards, pursuant to VHA Handbook § 1100.18.
- (3) A proposed reprimand was issued to the Associate Chief Nurse for Extended Care on June 3, 2002. On June 27, 2002, this individual received a decision letter to reprimand and a performance improvement plan.
- (4) On June 3, 2002, the agency issued a written counseling to the Assistant Nurse Manager.

² The agency included a copy of the Office of the Inspector General investigative report, dated June 13, 2002, among the documents it submitted to OSC.

- (5) The facility implemented a new tracking system to ensure that all patients receive their meal trays or tube feedings as scheduled. The facility also trained staff on the importance of nutritional intake.
- (6) To ensure that nurses follow established bar code medication administration (BCMA) procedures, all nurses were provided a copy of Medical Center Memorandum No. 00-46, "Administration of Medication using BCMA." In addition, the facility's BCMA policies and procedures will be discussed at monthly staff meetings.
- (7) The facility implemented the Expert Panel Staffing Methodology to evaluate the effectiveness of management decisions in the unit. In addition, the registered nurses in the unit received training on making work assignments and on team nursing concepts.
- (8) The Associate Chief Nurse for Extended Care, all extended care nurse managers, and all assistant nurse managers were enrolled in courses designed to improve their supervisory skills.
- (9) All staff members in the unit were issued Extended Care Memorandum 118C-B-22, "Patient/Family Concerns."
- (10) The Associate Chief Nurse for Operations, a Human Resources Specialist, and a union representative met with all employees on the unit to explain the processes available to them for reporting complaints and to assure them that they could voice their concerns without fear of reprisal.

Conclusion

Based on the representations made in the report and as stated above, I have determined, pursuant to 5 U.S.C. § 1213(e)(2), that the findings in the agency report appear reasonable. However, the agency report does not contain all of the information required by statute. Title 5, United States Code, Section 1213(d) enumerates several items that must be included in an agency report submitted to OSC, including a description of "disciplinary action against any employee" "taken or planned as a result of the investigation." 5 U.S.C. § 1213(d)(5). I interpret this provision as requiring the agency to provide the names of the disciplined employees, as a description of disciplinary action is less useful if it does not identify the employee against whom it was taken. Accordingly, on July 18, 2002, this office requested that the VA revise its report to include the names of the subject officials, but the agency refused to comply with our request. Given the role of 5 U.S.C. § 1213 as a vehicle for Government accountability and the high degree of public interest in the cases transmitted for investigation pursuant to this statute, I find the agency report to be deficient on this limited basis.

The Special Counsel

The President

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As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of the report to the Chairmen of the Senate and House Committees on Veterans' Affairs. We have also filed a copy of the report in our public file and closed the matter.

Respectfully,

A handwritten signature in black ink, appearing to read 'E. Kaplan', written in a cursive style.

Elaine Kaplan

Enclosure