



U.S. OFFICE OF SPECIAL COUNSEL

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October 3, 2007

The Special Counsel

The President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-07-1039

Dear Mr. President:

I received a disclosure from Mr. Roosevelt Keyes, Jr., a whistleblower formerly employed at the Department of Veterans Affairs (VA), VA Medical Center (VAMC), Palo Alto, California. Mr. Keyes, a former VAMC nursing assistant, alleged that patients in the VAMC Spinal Cord Injury (SCI) Unit received substandard medical care, and that VAMC SCI Unit nursing assistants were working outside their job classifications and performing tasks that should have been completed by a registered or licensed nurse.

I required the Honorable R. James Nicholson, Secretary of Veterans Affairs, to conduct an investigation into the whistleblower's disclosures pursuant to 5 U.S.C. § 1213(c) and (d). The Secretary submitted an agency report completed by VA Office of the Medical Inspector (OMI). Although the agency did not substantiate Mr. Keyes' allegations, the report reflected that agency managers had taken affirmative steps to address healthcare and job function issues.

Specifically, the investigation revealed that VAMC Associate Chief of Staff for Nursing, while denying that there was a violation of a law, rule or regulation or a substantial and specific danger to public health and safety, acknowledged that there had been challenges related to VAMC SCI Unit staffing and patient care. She emphasized that several interventions had helped alleviate these healthcare concerns, such as keeping the patient census down, hiring additional nursing and support staff, promoting nursing assistants from Grade 5 to Grade 6 in order to reflect more accurately increased job responsibilities, and providing retention bonuses to keep quality workers.

The report also found VAMC Nursing Handbook (Handbook) required editing because it incorrectly stated that nursing assistants should be assessing pressure to decubitus ulcers and, consequently, OMI requested that the Handbook be updated. Lastly, although OMI found that the nursing assistants were competent, experienced, and generally well-trained, it concluded that nursing assistants were not offered a formal medication course, as required by VHA Directive 2006-049. However, OMI found no violation of clinical practice. Nevertheless, the report cited

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that VAMC was undertaking affirmative action to improve medical treatment and care, including:

1. VAMC will update the "Spinal Cord Injury Center Competency Based Orientation Program" documentation packet to include the current orientation tasks and competencies that reflect only authorized nursing assistant functions;
2. VAMC will ensure that the SCI Unit develops a policy delineating the specific bladder, bowel and wound care treatments to include medications that are within the nursing assistant scope of practice;
3. VAMC will immediately disseminate and implement the formal medication course for unlicensed assistive personnel working in the SCI Unit; and
4. VA OMI will confirm all the actions are completed in a reasonable time and will notify OSC when those actions are completed.

On September 17, 2007, OSC contacted VA in order to inquire about the status of these tasks. Ms. Patricia Murray, VA OMI Director of Clinical Investigations, provided a matrix describing the tasks, the responsible person(s), current status, and target date. Ms. Murray was confident that VAMC would complete all tasks prior to October 5, 2007, and reconfirmed that she would notify OSC when all actions were completed.

Mr. Keyes' comments acknowledged that he was pleased that VAMC had taken remedial steps to address substandard treatment concerns, but expressed regret that VAMC did not act when these issues were first brought to their attention. As required by law, 5 U.S.C. § 1213(e)(3), I am now transmitting the agency's report along with the whistleblower's comments to you.

I have reviewed the original disclosures, the agency report, and the whistleblower's comments. Based on that review, I have determined that the agency's report contains all of the information required by statute, and that its findings appear to be reasonable.

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

Respectfully,



Scott J. Bloch

Enclosures