



DEPARTMENT OF VETERANS AFFAIRS  
UNDER SECRETARY FOR HEALTH  
WASHINGTON DC 20420

OCT 09 2007

The Honorable Scott J. Bloch  
Special Counsel  
U.S. Office of Special Counsel  
1730 M Street, NW  
Suite 300  
Washington, DC 20036-4505

Dear Mr. Bloch:

I am providing further information regarding the Department of Veterans Affairs (VA), Veterans Health Administration's (VHA) planned follow-up actions in response to the one recommendation in VA's report submitted in connection with Office of Special Counsel File Number DI-06-2205. As you will recall, that recommendation directed the facility to ". . . take a critical and formal approach to reviewing the policy to abolish the Nursing Administrative Officer of the Day (AOD) role considering its impact on patient safety and employee satisfaction." Subsequent to our submission of VA's report, your office communicated its concerns regarding the adequacy of VHA's response and action plan to carry out that recommendation.

While the Office of the Medical Inspector report did not identify clinical, safety issues or adverse events resulting from the policy change, VHA identified administrative concerns related to staffing which have arisen due to the current policy, e.g., seriously low morale among affected nursing staff. I recognize that these issues have the potential to lead to negative outcomes; thus, the facility will be required to re-evaluate whether the administrative concerns caused by implementation of the policy (as identified by the Medical Inspector) will create any risk to patient safety or adversely affect or compromise the quality of care provided to patients. In other words, although the AOD was not providing nursing services and was administrative in function, we will determine whether the lack of AOD involvement interferes with the furnishing of needed nursing care.

I assure you that VHA uses a stringent performance management program evaluating hundreds of clinical measures on an ongoing basis to ensure we maintain the highest quality of care. Issues that could result in any denigration of care are taken very seriously and addressed quickly.

To date, the facility has submitted a request to the Organization Excellence Board (OEB) for re-evaluation of the nursing AOD role redesign. The

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The Honorable Scott J. Bloch

Associate Director for Patient/Nursing Services met with the Performance Improvement Coordinator who is organizing a group of multidisciplinary team members to interview doctors, nurses, administrative officers and stakeholders as an initial step in the re-evaluation process. This initial phase will begin in the next two weeks and a full assessment is expected by December 15, 2007.

The work of this team will be monitored by the office of the Clinical-Quality Liaison for the Office of the Deputy Under Secretary for Health for Operations and Management here in the Veterans Health Administration Central Office. The results will be reported to the Office of the Medical Inspector in response to their recommendation that the policy change be reviewed.

Please be assured that we take any potential threat to delivery of high quality care to veterans very seriously and we will take any necessary corrective action recommended by the review.

Sincerely yours,

*M. J. O. Kinnaman, M.D.*



DEPARTMENT OF VETERANS AFFAIRS  
UNDER SECRETARY FOR HEALTH  
WASHINGTON DC 20420

APR 13 2007

Mr. Scott J. Bloch  
U.S. Office of Special Counsel  
1730 M Street, N.W. Suite 300  
Washington, DC 20036-4505

Dear Mr. Bloch:

Enclosed is the Department of Veterans Affairs (VA) report in response to your request of December 19, 2006, to investigate allegations of inadequate nursing supervision at the VA Medical Center, Houston, Texas, by a registered nurse, Ms. Valerie Taylor (Office of Special Counsel File Number DI-06-2205). The Secretary of Veterans Affairs has directed me to review and sign this agency report and to take any actions deemed necessary under 5 U.S.C § 1213 (d)(5).

Upon receipt of your letter, I tasked the Office of the Medical Inspector (OMI) to conduct a site visit to the Medical Center and review the issues related to the complaint. The OMI findings are set forth in the enclosed report. The OMI did not substantiate the allegations of the complainant; however, areas of improvement were identified and are outlined in the report. These have been discussed with the Medical Center Director and Chief Nurse Executive, and an action plan is being developed to address the findings.

If you have any questions about the content of the report, please have a member of your staff contact Mr. Terry A. Morrow, FACHE, Director, Operations and Administration Staff, Management Support Office, at (202) 273-8887.

Sincerely yours,

*Michael J. Kussman, M.D.*  
Michael J. Kussman, MD, MS, MACP  
Acting Under Secretary for Health

Enclosure

**Report of Investigation to the U.S. Office of Special Counsel  
OSC File Number DI-06-2205**

The Office of the Medical Inspector (OMI) was asked by the Acting Under Secretary for Health to review a complaint lodged with the Office of Special Counsel (OSC) by a registered nurse (RN) employed at the Michael E. DeBakey Veteran Administration Medical Center, Houston, TX (hereafter the Medical Center). The complainant, a Nurse Manager on a mental health inpatient unit, raised allegations concerning the health and safety of patients at the Medical Center. More specifically, the complainant alleges:

1. Nurses on the Medical Center's inpatient units do not have adequate supervision in the evenings, on weekends, and on holidays. The Nursing Administrative Officers of the Day (AOD), (known in many hospitals as the evening and night nurse supervisor), no longer work on site during off-tour hours<sup>1</sup>; these positions have been abolished. The nursing staff must now contact an on-call Nurse Manager<sup>2</sup> for guidance and medical advice.
2. The policy, initiated in January 2006, eliminating the AOD on off-tours hours, requires the on-call Nurse Manager to provide medical advice over the phone without examining the patient firsthand. The complainant contends there is a high risk of misdiagnosis or medical error.
3. The Texas Board of Nurse Examiners indicates that the Nurse Managers are jeopardizing their nursing licenses by providing clinical advice in this manner.
4. The on-call Nurse Managers provide supervision and medical advice over the phone because nursing staff do not have anyone else to consult. Residents are available in the emergency room during off-tour hours, but they are unfamiliar with the rules, procedures, and policies of the VAMC.
5. The absence of Nurse AODs during off-tour hours hinders the Medical Center's ability to thoroughly investigate medical emergencies that arise at such times. The complainant asserts that Nurse Managers have to investigate these events during their normal day shift, relying exclusively on second-hand information. She reports this time delay compromises the integrity and accuracy of the evidence they gather.

**Facility Profile**

The Medical Center operates 355 hospital beds; there is an additional 40-bed Spinal Cord Injury Center and 120-bed unit for long-term care. The Medical Center employs over 3,000 people. It has a large number of training programs, with over 1,000 students and 580 residents rotating through annually; from over 85 affiliate schools in 13 states.

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<sup>1</sup> Off tour hours are hours worked during evenings, nights, weekends and holidays.

<sup>2</sup> Each nursing unit, inpatient or outpatient, generally has its own RN Nurse Manager who is clinically and administratively responsible for the unit.

The Medical Center is home to a Post Traumatic Stress Disorder Clinic; a regional Polytrauma Center; a Cardiac Surgery Program; and one of VA's six Parkinson's Disease Research, Education, and Clinical Centers. Including its satellite clinics in Beaumont, Lufkin, Galveston, and Texas City, the Medical Center logged more than 800,000 outpatient visits in fiscal year 2006. It provides care to about 137,000 veterans in its primary service area.

A member of the Veterans Integrated Service Network (VISN) 16, the current Medical Center facility was built in 1991 on a 118-acre campus in Houston; it is fully accredited by JCAHO and CARF and was awarded Magnet Recognition for Excellence in Nursing Services by the American Nurses Credentialing Center (ANCC) in August 2004. It hosts a research program with over \$17 million in annual support. The Medical Center has continued to lend support to veterans displaced by Hurricane Katrina and to sister VA facilities in the Louisiana and Mississippi regions.

### **Methods for Conducting the Investigation**

The OMI notified the Medical Center Director of the complaint and of its plans for a January 8-9, 2007 site visit. The Chief Nurse Executive and her staff coordinated the visit. The OMI team consisted of the Medical Inspector (a physician), the OMI clinical psychologist, and an OMI investigator (a nurse practitioner), all from Veteran Affairs Central Office, in Washington, DC. The OMI team received full cooperation from the Medical Center staff as it conducted individual and group interviews, and reviewed both policy and patient care documents.

Entrance and exit conferences were held with the Medical Center leadership. The team interviewed the Director, the Chief Nurse Executive, the Chief of Staff, and the complainant. Group interviews were conducted with the Associate Chief Nurse and all 5 Care Line Nurse Executives, 6 of the previous Nursing AODs, 22 of the Medical Center's 35 Nurse Managers, over 32 Charge Nurses<sup>3</sup> from the evening and night shifts, 4 Care Line Executives, and 11 resident physicians who were in various post graduate years of training.

The OMI reviewed the patient medical records of the cases provided by the complainant, the minutes from Nurse Manager Council meetings, nursing functional statements (job descriptions), resident physician call schedules, nursing policy and other documents relating to development of the new policy on the Nursing AOD, nursing surveys, and salary dollars expended on the previous Nursing AOD positions.

### **Documents Reviewed:**

- *The Administrative Officer of the Day Reorganization Workgroup Report (May 5, 2005)*

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<sup>3</sup> Charge nurses are staff RNs that have, in addition to patient care assignments, administrative/ supervisory duties during a shift.

- Position descriptions for the Nursing AOD, the Nurse Manager, and the Clinical Practice Manager
- Resident physician on-call schedules for the four most recent months
- A White Paper on the issue by the Chief Nurse Executive
- Salary dollars expended in FY2005 for the Nursing AOD positions
- Nurse Manager Council minutes for 2005
- The *AOD/NOD Survey Medical Group 7 and VISN 16*
- A review of how other VAMCs (300 operating beds) operate without Nursing Supervisors
- Two patient medical records
- The Staff Nurse and Nurse Manager surveys of January 2006
- *Nursing Practice Act, Nursing Peer Review & Nurse Licensure Compact of the Texas Occupations Code and Statutes Regulating the Practice of Nursing, as amended September 2005, Section 301.002.* Retrieved from <http://www.bne.state.tx.us/nursinglaw/npa.html>, on January 25, 2007.

## **Background**

Historically, there were two positions in the Medical Center during off-tour hours (weekdays 4:30 pm to 8:00 am, weekends and holidays) that had some overlapping duties. The Nursing AOD's duties included both clinical and administrative functions, many of which, according to the Medical Center, could be performed by non-nursing administrative personnel. The second position is the Medical Administrative Assistant (MAA). The primary function of the MAA is to coordinate and implement administrative activities facility-wide. Over time it was determined that the Nursing AOD role had evolved into that of administrative facilitator as well as clinical expert. The Nurse AOD was generally a senior experienced nurse with significant inpatient and/or critical care experience. Clinical duties performed by the Nursing AOD included managing narcotics exchanges between units (borrowing), helping manage emergencies by responding to Code Blue (medical) and Code Green (psychiatric) emergency situations, managing 'medical clearance' for mental health admissions, initiation and management of a disaster cascade to include leadership notifications, providing 'expert' nursing guidance on clinical and ethical issues, accessing blood bank personnel and requests for blood, management of operating room deaths, and, maybe most importantly, acting as a seasoned clinical nursing resource for staff nurses when guidance, advice or decision making was needed. The administrative issues handled by the Nursing AOD involved facilitating patient transfer, securing beds for patient admissions and resources from community hospitals as needed, granting leave, providing computer password codes, clearing electronic signatures, opening secured doors, and transporting supplies. The MAA identifies available beds for patient admissions, inter and intra-VA facility and community transfers, secures patient funds, provides decedent-affairs activities, and secures resources from community hospitals as needed.

The genesis of the changes affecting the nursing AOD position appears in a January 7, 2005 memorandum from the Chief Nurse Executive and the Business Office Service Line Executive. It was clear from this document that the Clinical

Practice Office (nursing office) and the Business Office had “partnered together” to reorganize the Nursing AOD positions through conversion of the positions to non-patient care nursing positions “in which funding are [is] not available given the cost efficiency measures associated with the budget.” A recommendation was made to form a redesign workgroup, although the decision to abolish the Nursing AOD role was made in January 2005.

In a partnership between the Clinical Practice Office (Nursing Service Office) and the Business Office Service Line, a multidisciplinary Nursing AOD Work group met from February – May 2005 with the overall focus of reorganizing/redesigning the Nursing AOD position. The major goal for the change was the reallocation of FTEE salary dollars for the creation of four new Clinical Practice Manager roles within the Clinical Practice Office. These positions are responsible to the Associate Chief Nurse and their primary responsibility is to direct “...practice according to established policies, standards of care, and standards of practice” (Criteria Based Functional Statement, Clinical Practice Manager, Nurse III).

The MAA is still present during off-tour hours. Since the policy change, staff nurses must go to their Charge Nurse for staffing, administrative, or nursing care issues during off-tours. If the Charge Nurse is unable to solve the problem, the Nurse Manager is called at home. Nurse Managers are now ultimately responsible for issues arising in their units during off-tour hours and are now on-call 24/7 to accommodate these additional responsibilities.

There is no agreed-upon industry standard for providing supervisory coverage during off-tour hours. A look at how other facilities handled this issue through the AOD/NOD Survey Medical Group 7 and VISN 16 revealed that of six hospitals reporting, five employ an AOD from the business office and a Nursing AOD or nursing supervisor for off-tour hours. One hospital (120 beds) reported only an AOD (Business Office) and a full-time RN Staffing Coordinator. A like-sized VA Medical Center eliminated their Nursing AOD roles, but employs a hospital wide “acute side” Charge Nurse (without any patient assignments) during off-tour hours. In addition they have a separate staffing pool of intermittent on-call employees and a staffing agency when needed. The Nurse Managers are on call but this is rotated and they receive on-call pay. They report no mandatory overtime. While there are recommendations for the number of nurses needed on specialty units (for example, acute medical and surgical wards), these would be developed at the Medical Center or VISN (Veterans Integrated Service Network) level. The need for supervisory nurses to cover evenings, nights, weekends and holidays is a decision based upon the unique needs and policies of the Medical Center.

### **Findings**

The OMI team interviewed the complainant, who has 22 years experience as an RN, and 9 years as a Nurse Manager, in both the private sector and during her 5 years with VA. The OMI was able to talk with the complainant during our visit on two more occasions to obtain clarification and seek additional information. Issues raised included the lack of compensation for Nurse Managers taking regular on-call duties; the potential for adverse

incidents when Charge Nurses have to manage staffing and patient flow problems while continuing their patient care duties; increase in overtime; short staffing; and decreased nursing morale. The complainant admitted that Nurse Managers do not give medical advice nor diagnose over the phone, but are solicited on-call for nursing advice, staffing, patient flow, and administrative issues. The complainant has conducted a year-long campaign for re-evaluation of the abolition of the Nursing AOD role.

When asked for specific patient care events that occurred secondary to the new policy the complainant provided two patient incidents that she related to this change in policy. The OMI reviewed these events and found that both events occurred within the month prior to the implementation of the new Nursing AOD policy in January 2006. The OMI advised the complainant about the mistiming of these events. Regarding resident physicians, there were no incidents reported regarding a compromise of patient safety and the lack of resident knowledge about the policies and procedures of the VAMC.

An interview with the Chief Nurse Executive revealed that she accepted her position about 3 months after implementation of the January 2006 policy to abolish the Nursing AOD role. She reports that a multidisciplinary committee provided guidance and received feedback on the policy, prior to implementation. Many former duties of the Nursing AOD were allocated to the MAA, the Nurse Managers, or Security. The Nurse Education Office reported preliminary results of a ten-question survey of staff nurses and nurse managers, given in January 2006 and repeated in April and August 2006; although the response rates were low (in one survey, three NMs responded) and findings inconclusive. While the Clinical Practice Office reported overall positive responses for nursing satisfaction on the 2006 All Employee Survey, they provided OMI the results for their 22 separate nursing units. A collated roll-up of the data for generalization to all nurses in the Medical Center was not provided.

An interview was conducted with the five Care Line Nurse Executives; also in attendance was the Associate Chief Nurse. All concurred with the value of the previous Nursing AOD role, and there was little response when asked whether the new policy was working. They spoke of the adaptations some Care Lines had made to compensate for the gaps in off-tour coverage. Some have hired Care Line bed control/flow coordinators and some have shifted their RN staffing to enhance off-tours. The Extended Care Unit provided their Nurse Managers with cell phones to replace pagers. There were some issues with Code Green (psychiatric) and Code Blue (medical) emergencies as the Nursing AOD had attended all codes. A Code Green requires the attendance of a mental health RN and a Code Blue requires a critical care RN. These episodes have the potential to critically reduce staff in the Mental Health Unit and ICU's, as both have a greater population of patients requiring one-on-one care. Previously, the Nursing AOD would have solved issues with the movement of staff from one unit to another to accommodate temporary staffing losses. However, no specific adverse incidents were identified when we queried the Care Line Nurse Executives, nor was there specific data provided to the OMI that outcomes had been affected.

While it was stated by the Care Line Nurse Executives during interviews that the role of Nurse Manager was a 24 hours per day, 7 days a week job, the OMI could not find

documentation to support this requirement in the Medical Center's functional statement for this position. The OMI team reviewed the Medical Center's *Criteria Based Functional Statement, Nurse Manager* and *VA Handbook 5007, Part III, Chapter 8: Higher rates of pay for assignment as head nurse or possession of specialized skills* and did not locate this stipulation. The OMI requested confirmatory information regarding this role requirement from the Clinical Practice Office (Nursing Service Office) on January 24, 2007 and received this clarification: "The functional statement for the NM under Leadership #1 for Nurse II and III- states: Demonstrates knowledge of scope of practice and RN accountability in assignment, delegation and supervision of staff." They expressed that this "implies 24 hr. accountability."

The OMI interviewed 22 Nurse Managers. Within this animated group their consensus opinion was that the abolition of the Nursing AOD role imposed an additional burden upon both the nursing staff and the Nurse Managers. The Nurse Managers agreed that this change has resulted in many nights of interrupted sleep and problem solving, either by telephone or their presence on the unit. Most units have one Nurse Manager and have arranged to share the call schedule with Nurse Managers of other inpatient units within their Care Lines. Presently, the Nurse Managers, after working their normal tour, are on-call on a rotational basis and are frequently consulted. While on call, Nurse Managers may need to converse with staff, residents, the MAA, the Nurse Care Line Executive or patient families. The Nurse Managers felt the Nursing AOD had provided expert nursing oversight for the Medical Center and was viewed as a valuable resource for staffing, bed control, medical emergencies (cardiac/respiratory arrest), supply access, patient and family advocacy, and nursing advice. The Nursing AOD was a valuable resource during an emergency code situation. While the resident or attending physician assigned to the code team would be in charge of conducting the code and medical decision making, the Nursing AOD provided an extra pair of experienced hands, as well as expert guidance in ensuring the coordinated flow of persons and activities. This may include documentation, location of drugs and supplies, assisting staff, accessing pertinent patient data and patient transfer. Despite their concerns about a possible adverse affect on patient care; they were unable to give any specific examples of an untoward effect on an individual veteran.

Without the Nursing AOD, many Nurse Managers said they were functioning in "crisis mode" and, "that there is no one in the house that looks at the whole picture," ... "no one can move people around" to accommodate short staffing. The Nurse Managers do not receive compensation for these additional on-call duties nor for coming in to manage issues needing their physical presence.

The OMI interviewed six nurses who previously occupied the Nursing AOD role. They were experienced nurses, most with a critical-care background, who are able to solve staffing, supply, bed availability, manage healthcare emergencies and other problems with ease. Most had been a Nursing AOD for 10 or more years. They concurred with others interviewed regarding the global outlook of the Nurse AOD and reported that their effectiveness and efficiency was often a result of the historical authority implicit in their role. They had resources for staffing and were able to resolve bed availability concerns, acted as resource persons during a cardiac or respiratory arrest, and had staffing pools

they tapped when necessary. They reported that, as a group, they felt they were not consulted about the policy proposal, but were instead simply informed of the change.

The OMI interviewed over 30 Charge Nurses, meeting separately with the night and evening shifts. They report low morale in their group because of the Nursing AOD change. They note difficulty in patient transfers to the intensive care units (ICU), difficulty staffing, increased workload burden, and they are unclear about the new policy rationale. Charge or staff nurses contact the Nurse Manager for nursing advice; they contact a resident or attending physician for medical advice. When asked, nearly all stated they would not seek a Nurse Manager role, because of the additional, uncompensated burden and stress. They report increased required overtime, but note they may not call it mandatory overtime, as mandatory overtime is discouraged in a Nursing Magnet status hospital. Some are now required to report 30 minutes earlier (unpaid) to accommodate these additional duties. An incident was reported anonymously of a Charge Nurse being required to stay with a Code Blue patient for 3 hours, during which time she was unable to care for her normal panel of patients, while attempts were made to get an ICU bed. The burden of care for her patients fell on the other staff nurses within the unit. Another anonymous report alleged that a veteran's spouse had died in courtesy quarters and that there was no one to wrap and care for the body, as the MAA was unable to perform this task. We were advised that the facility investigated this incident. The Charge Nurses agreed that a Nursing AOD would have facilitated both events.

The OMI met with four Care Line Directors to discuss the impact of the policy. There was general consensus that the new policy has hindered communications, hand-off or transfer of patients to personnel on the next shift, access to supplies and the operating rooms, and decreased efficiency in Codes Blue and Green situations during off tour hours. The Nursing AOD often acted as the process expert in a Code situation; lending knowledge and expertise and acting as a supply resource person or substitute staff member. They sense decreased morale in Nurse Managers and Charge Nurses. They also agreed, like others, about the benefits of the Nursing AOD role; however they thought the functions of the Nursing AOD might also be handled in some other way. One Care Line has hired a patient flow coordinator. They report the Clinical Executive Board had little input opportunity prior to approval of the policy.

The OMI interviewed 11 resident physicians who were at various post graduate years of training. Most were surgical residents and only two were present prior to the implementation of the new policy, so there was little recollection of the previous process. They all noted an increased patient workload due to the patient volume effect from Hurricane Katrina. Because of the large resident physician population, we discovered that units are covered at all times by a specialty resident or attending physician who is available in person, by pager or telephone. Resident physicians receive an orientation to the VAMC regarding the rules, policies and procedures within the VA system.

A telephone interview was conducted with two consultants from the Practice Issues Section of the Texas Board of Nurse Examiners (BNE) on January 24, 2007.

*The Texas Occupations Code and Statutes Regulating the Practice of Nursing, As Amended September 2005*, <http://www.bne.state.tx.us/nursinglaw/npa.html> (retrieved January 25, 2007), Sec. 301.002 (2) and (5) defines “Professional Nursing” as,

The performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing. The term does not include actions of medical diagnosis or the prescription of therapeutic or corrective measures. Professional nursing involves: (A) the observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a person who is ill, injured, infirm, or experiencing a change in normal health processes; ... (E) the administration, supervision, and evaluation of nursing practices, policies, and procedures;

The Texas BNE Practice Issue consultants concurred there was no threat to a Nurse Manager’s (RN) licensure when providing supervisory advice over the phone to staff nurses within her unit if this process remains within the scope of nursing activities (described under the nursing standards for the nurse’s state of licensure).

### **Conclusions**

**Allegation #1: Nurses on the Medical Center’s inpatient units do not have adequate supervision in the evenings, on weekends, and on holidays. The Nursing Administrative Officers of the Day (AOD) (known in many hospitals as the evening and night nurse supervisor), no longer work on site during off-tour hours: these positions have been abolished. The nursing staff must now contact an on call Nurse Manager for guidance and medical advice.**

*OMI Conclusion:* The OMI found that the Nurse Administrative Officer of the Day (AOD) positions had been abolished and were, therefore, no longer on site and that the Nurse Managers are on-call as indicated by the complainant. The OMI found that the nurses on the inpatient units do have adequate supervision; however, these arrangements have taken a toll on the Nurse Managers. The OMI did find that most Nurse Managers and Charge Nurses felt the Nursing AOD had provided a ‘safety net’ over the entire Medical Center and this person had a ‘global view’ of the Medical Center, allowing for better, faster and more efficient problem solving. Many nurses perceive the absence of the Nurse AOD on off tours as the loss of a valued nursing resource, guide and emergency manager. However, the OMI found no specific examples of harm to patients nor was the OMI shown any data to demonstrate evidence of poor outcomes.

**Allegation #2: The policy, initiated in January 2006, eliminating the AOD during off-tours hours, requires the on call Nurse Manager to provide medical advice over the phone without examining the patient firsthand. The complainant contends there is a high risk of misdiagnosis or medical error.**

**OMI Conclusion:** Nurse Managers are not providing medical advice or diagnosis over the phone. Nurses contact resident or attending physicians when patients require medical attention. We found no evidence of any 'medical' error occurring as a result of this policy change, although the OMI feels the heightened vigilance of nursing staff has possibly prevented adverse events.

**Allegation #3 The Texas Board of Nurse Examiners indicates that the Nurse Managers are jeopardizing their nursing licenses by providing clinical advice in this manner.**

**OMI Conclusion:** The OMI found no evidence to suggest that RNs at this Medical Center, in the role of Nurse Managers, are providing advice prohibited by the *Texas Nursing Practice Act*, as outlined in *The Texas Occupations Code and Statutes Regulating the Practice of Nursing, As Amended September 2005*, Sec. 301.002 (2) and (5) <http://www.bne.state.tx.us/nursinglaw/npa.html> (retrieved January 25, 2007).

**Allegation #4: The on-call Nurse Managers provide supervision and medical advice over the phone because nursing staff do not have anyone else to consult. Residents are available in the emergency room during off tour hours, but they are unfamiliar with the rules, procedures, and policies of the VAMC.**

**OMI Conclusion:** The OMI found that Nurse Managers do not provide medical advice over the phone; they do provide nursing advice. Resident and attending physicians are available to address the medical needs of the patients 24 hours a day. Many resident physicians are in the hospital during off-tour hours while others may take call from home. There are in fact no resident physicians assigned to the emergency room on a regular basis; however, they may occasionally be present in the emergency room to answer a consultation for their service. Residents receive orientation to the rules, procedures and policies of the VAMC, and there was no evidence to suggest that adverse events were caused by a lack of this knowledge.

**Allegation #5: The absence of Nursing AODs during off-tours hinders the Medical Center's ability to thoroughly investigate medical emergencies that arise at such times. The complainant asserts that Nurse Managers have to investigate these events during their normal day shift, relying exclusively on second-hand information. She reports this time delay compromises the integrity and accuracy of the evidence they gather.**

**OMI Conclusion:** The OMI did not determine that there was any compromise to the integrity or accuracy of the reporting of serious medical events or medical emergencies. It was determined that staff nurses and charge nurses are responsible for completing reports on any medical situations or occurrences during their duty time. None of those interviewed could recall any problems with these reports and the complainant could not site any such problems.

In summary, the OMI did not substantiate the allegations made by the complainant. No violation of clinical practice or apparent violation of any law, rule, or regulation was found. The OMI did not find any evidence to suggest that this change in policy poses a substantial and specific danger to the health and safety of patients.

The OMI did discover that the nature of the duties and responsibilities of the Nursing AOD role allowed this individual a “global view” of a large, complex hospital system. These experienced clinicians provided a “safety net” for nursing staff, facilitated processes on off-tours and holidays, and managed many multidisciplinary issues, all contributing to the safety and well-being of veteran patients. These responsibilities now fall on the shoulders of the unit Nurse Manager and Charge RNs.

### **Recommendation**

The OMI recommends that the Medical Center take a critical and formal approach to reviewing the policy to abolish the Nursing AOD role considering its impact on patient safety and employee satisfaction.