



**U.S. OFFICE OF SPECIAL COUNSEL**

1730 M Street, N.W., Suite 218

Washington, D.C. 20036-4505

202-254-3600

**Analysis of Disclosures, Agency Investigation and Reports, and Whistleblower Comments**

**OSC File No. DI-06-2205**

**Summary**

Valerie Taylor, Registered Nurse (RN), disclosed to OSC a substantial and specific danger to public health and safety arising out of actions by officials at the Department of Veterans Affairs (VA), Michael E. DeBakey VA Medical Center (VAMC), Houston, Texas. Specifically, Ms. Taylor alleged that the nurses in the VAMC's inpatient units do not have adequate supervision in the evenings, on weekends, and on holidays. Ms. Taylor stated that the VAMC eliminated the Nursing Administrative Officer of the Day (AOD), who used to provide valuable on-site clinical and administrative assistance to the nursing staff during off-tour hours. Under the present arrangement, the nursing staff must now contact an on-call Nurse Manager at home for guidance and nursing advice during off-tour hours. Because the Nurse Managers provide nursing advice over the telephone, without examining the patient firsthand, Ms. Taylor contended that there is a high risk of medical error.

The VA, Office of the Medical Inspector (OMI) investigated Ms. Taylor's allegations. The allegations were not substantiated by the investigation. The OMI concluded that the VAMC's decision to eliminate the AOD position has created administrative and staffing problems and has led to low morale among the nursing staff. However, the OMI did not find that the new policy posed a danger to the health or safety of the VAMC patients.

**The Whistleblower's Disclosures**

Ms. Taylor, who consented to the release of her name, has been a Registered Nurse since 1985. She began working as a Nurse Manager at the VAMC in 2001, but in 2006, she decided to step down from this position in order to become a Staff Nurse. She currently works in the Psychiatric Evaluation and Assessment Clinic.

Ms. Taylor advised that, in September 2005, VAMC management eliminated the Nursing AOD position. In order to cover the duties previously performed by the AOD, the VAMC instituted a new policy that requires the Nurse Managers assigned to inpatient units to be on call, on a rotating basis, in the evenings, on weekends, and on holidays. When Ms. Taylor worked as a Nurse Manager in the Mental Health Unit, she rotated on-call duties with two other Nurse Managers. Under the current policy, the on-call Nurse Manager is primarily tasked with addressing administrative and staffing concerns; however, they also handle clinical issues and provide medical advice by default, as there are no Nurse Managers present on-site during off-tour hours.

Ms. Taylor contended that this policy poses a substantial and specific danger to the health and safety of the patients as it requires the Nurse Managers to provide medical advice over the phone, without the opportunity to examine patients firsthand. She maintained that it is very difficult to assess a patient's condition and provide accurate medical advice without being able to physically examine the patient. Ms. Taylor stated that she consulted the Texas Board of Nurse Examiners about this situation, and their representative advised her that she and the other Nurse Managers are jeopardizing their nursing licenses by providing clinical advice in this manner. Nevertheless, the Nurse Managers continue to provide supervision and medical advice over the phone, because the nursing staff does not have anyone else they can consult. Although Resident Physicians are present in the emergency room during off-tour hours, Ms. Taylor maintained that these physicians rotate through the units fairly quickly and they are generally unfamiliar with the VAMC's rules, procedures, and policies.

Ms. Taylor further alleged that the absence of Nurse Managers during off-tour hours hinders the VAMC's ability to thoroughly investigate medical emergencies that arise at such times. She explained that, in general, when a serious medical incident occurs, the Nurse Manager on-duty is responsible for ascertaining the facts surrounding the incident, interviewing the responsible personnel, and filling out the appropriate paperwork. However, now that Nurse Managers no longer work off-tour hours, they have to investigate medical emergencies that arise at these times, during their next shift, after-the-fact. Ms. Taylor asserted that the time delay often compromises the integrity and accuracy of the evidence that the Nurse Manager is able to gather. She explained that the Nurse Manager must now rely exclusively upon second-hand information and is now unable to examine the condition of the patient and the scene of the incident immediately after the incident occurs.

#### **Department of Veterans Affairs Investigation and Reports**

The VA, Office of the Medical Inspector (OMI) investigated Ms. Taylor's allegations. The OMI team consisted of the Medical Inspector, who is a physician; a clinical psychologist; and a nurse practitioner. The OMI team visited the VAMC on January 8 and 9, 2007. The investigators interviewed Ms. Taylor and several VAMC officials, including the Director, the Chief Nurse Executive, and the Chief of Staff. They also conducted group interviews with the Associate Chief Nurse and all 5 Care Line Nurse Executives, 6 of the previous Nursing AODs, 22 Nurse Managers, 32 Charge Nurses, 4 Care Line Executives, and 11 Resident Physicians. In addition, the investigators reviewed medical records, nursing position descriptions, nursing policy directives, and other relevant documents.

According to the agency report, in January 2005, the Chief Nurse Executive and the Business Office Service Line Executive decided to abolish the Nursing AOD position and restructure the nursing care lines. The Chief Nurse Executive stated that, prior to implementing the new policy, the VAMC sought guidance and feedback from a multidisciplinary committee. However, the Care Line Directors informed the investigators that the Clinical Executive Board had minimal opportunity to provide input on the new policy prior to its approval. In addition, the six employees who previously worked as AODs stated that they had not been consulted about the policy change prior to its implementation.

The agency report explains that, under the old policy, the AOD served both clinical and administrative functions during off-tour hours. The AOD's clinical duties included the following:

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 acting as a seasoned clinical nursing resource for staff nurses when guidance, advice or decision making was needed.

After abolishing the AOD position, the VAMC instituted a new policy for handling staffing, administrative, and nursing care issues during off-tour hours. Under the current policy, Staff Nurses must first consult the Charge Nurse on duty. When the Charge Nurse is unable to solve the problem, the Staff Nurse or Charge Nurse should call the Nurse Manager at home. Thus, the report states that, "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."

The OMI surveyed other VAMCs in Veterans Integrated Service Network (VISN) 16 to find out how they provide nursing supervision during off-tour hours. According to the agency report, of the six VAMCs that responded to the survey, five of them employ a Nursing AOD and an AOD from the Business Office. Another VAMC employs an AOD from the Business Office and a full-time RN Staffing Coordinator. The agency report further states that a like-sized VAMC also eliminated its Nursing AOD position. In place of the AOD, this VAMC now employs an "acute side" Charge Nurse during off-tour hours, it maintains a separate staffing pool of on-call nurses, and it compensates Nurse Managers with additional pay for performing on-call duties.

The witnesses reported on some of the measures the Houston VAMC has taken to compensate for the loss of the Nursing AOD. The Chief Nurse Executive advised that many of the duties previously handled by the Nursing AOD have since been allocated to the Medical Administrative Assistant, the Nurse Managers, and Security. The Care Line Nurse Executives stated that, in an attempt to fill in the gaps in off-tour coverage, some Care Lines have hired bed flow coordinators and some have adjusted their RN staffing levels to enhance off-tour hours. In addition, the report states that the Extended Care Unit replaced its Nurse Managers' pagers with cell phones.

In spite of the efforts the VAMC has taken to compensate for the loss of the AOD, the nursing staff reported that there are still significant gaps in coverage. First, the Care Line Nurse Executives relayed that they have encountered decreased efficiency in the staff's ability to respond to Code Blue and Code Green emergencies since the departure of the AOD. They explained that a Code Blue, which is a medical emergency such as a cardiac or respiratory arrest,

must be attended by a critical care RN, and a Code Green, which is a psychiatric emergency, must be attended by a mental health RN. The Care Line Nurse Executives explained that, as a result, these episodes have the potential to critically reduce staff in the Mental Health Unit and the Intensive Care Units. Previously, the AOD coordinated the movement of staff during these emergencies to ensure that all units were appropriately staffed. The Nurse Managers reported that, in addition, the AOD used to assist the resident or attending physician during Code Blues and Code Greens, thereby providing an extra pair of experienced hands. The Nurse Managers further advised that the AOD also provided other types of assistance during emergency codes, including completing documentation, locating drugs and supplies, accessing pertinent patient data, and transferring patients between units. They stated that the VAMC no longer has anyone during off-tour hours who is specifically assigned to assume these critical functions that were previously handled by the AOD.

The nursing staff also disclosed to the investigators other serious gaps in coverage that have arisen since the AOD position was eliminated. The Charge Nurses stated that, under the new policy, they have experienced difficulty transferring patients to the intensive care units and have also experienced difficulty maintaining adequate staffing levels. The Nurse Managers complained that there is no longer anyone present during off-tour hours who “looks at the whole picture” and “no one can move people around” to accommodate short staffing. The Care Line Directors asserted that “the new policy has hindered communications, hand-off or transfer of patients to the personnel on the next shift, [and] access to supplies and the operating rooms . . . during off tour hours.” Nurse Managers expressed concern that the loss of the AOD has affected the quality of patient care provided to veterans. The Charge Nurses related that they are uncertain about the rationale for the new policy, in light of the difficulties it has created. In spite of the foregoing concerns expressed by the nursing staff, the agency report emphasizes that the witnesses were unable to identify any specific adverse events that could be directly attributed to the new policy, nor were they able to provide specific data indicating that patient care outcomes had been affected.

The Nurse Managers reported to the investigators that the new policy has adversely affected their quality of life. The Nurse Managers complained that they spend many nights answering telephone calls from the nurses in their unit. They stated that they currently spend a great deal of their personal time solving problems over the telephone or driving back to the hospital to evaluate a situation in person. As a result, the Nurse Managers experience many nights of interrupted sleep. Several Nurse Managers related that, since the departure of the AOD, they have been operating in “crisis mode.” They also protested that it is unfair that they have not received compensation for assuming the additional on-call duties.

The Charge Nurses reported that the policy change has contributed to low morale among the nursing staff. They stated that their workload burden has increased significantly and, as a result, they are now required to work more overtime hours. Some Charge Nurses maintained that they now have to report to work 30 minutes earlier to complete their additional duties, but they are not paid for the additional time. When the investigators asked the Charge Nurses whether or not they were interested in seeking a promotion to a Nurse Manager position, nearly all of them indicated that they were not interested, due to the additional, uncompensated burden and stress that now accompanies the Nurse Manager position.

During Ms. Taylor's interview, the OMI team inquired about specific patient care incidents. The agency report states that Ms. Taylor relayed information about two incidents that she believes occurred as a result of the new policy. However, the investigators dismissed the information as irrelevant on the grounds that both events occurred prior to the implementation of the new policy in January 2006. The agency report also mentions two other patient care incidents that nursing staff alleged had occurred after the abolition of the AOD position. First, an anonymous witness reported that, on one occasion, a Charge Nurse was required to stay with a Code Blue patient for three hours while waiting for someone to locate an ICU bed, during which time she was unable to care for her assigned patients. Another anonymous source related that a veteran's spouse died in courtesy quarters, yet no one was available to wrap and care for the body. The Charge Nurses maintained that, under the old policy, the Nursing AOD would have effectively handled both of these incidents.

Finally, the OMI addressed Ms. Taylor's concern that Nurse Managers are dispensing medical advice over the telephone and thereby jeopardizing their nursing licenses. The investigators interviewed two consultants from the Practice Issues Section of the Texas Board of Nurse Examiners. The consultants advised that "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."

According to the agency report, the OMI team concluded that, under the current arrangement, the nurses working in inpatient units do have adequate supervision during off-tour hours. They also found that, when on call, the Nurse Managers do not actually provide *medical* advice over the telephone; however, they do dispense *nursing* advice, which is permissible. Furthermore, the OMI team did not find any evidence that the current policy compromises the nursing staff's ability to investigate and report on medical emergencies. On the other hand, the investigators did find that, under the old policy, the Nursing AOD had provided a "safety net" over the entire VAMC and had offered a "global view" that had allowed for "better, faster and more efficient problem solving." Thus, the OMI team concluded that the elimination of the AOD position has taken a toll on the efficiency and morale of the VAMC nursing staff.

Nevertheless, the OMI team concluded that the new arrangement does not pose a substantial and specific danger to public health or safety. In particular, they cite the fact that the nursing staff was unable to provide any specific examples demonstrating that patients have experienced harm due to the elimination of the AOD position. On the other hand, the OMI team acknowledged that "the heightened vigilance of nursing staff has possibly prevented adverse events." Based on the findings of the investigation, the OMI team recommended that the VAMC "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."

On July 5, 2007, OSC contacted the Veterans Health Administration (VHA) to express dissatisfaction with the report's conclusions. OSC informed the VHA that we believe the investigative findings show that the elimination of the Nursing AOD has left significant gaps in patient care. We also expressed the opinion that the staffing and morale problems uncovered by the investigation, because they are taking place in a hospital setting, necessarily have serious

implications for patient health and safety. In light of the deficiencies uncovered by the investigation, OSC asked the agency to pursue appropriate corrective action to remedy the situation. The VHA agreed to review the matter further.

The VHA submitted a supplemental report to OSC on October 9, 2007. The supplemental report states that the VHA plans to re-evaluate the VAMC's current policy, in response to the OMI's recommendation in the initial report. The supplemental report notes that the VHA identified administrative staffing concerns and low morale among the nursing staff due to the new policy, and the VHA acknowledges that "these issues have the potential to lead to negative outcomes." Therefore, according to the supplemental report, the facility will be required to re-evaluate whether the new policy compromises the quality of patient care or creates any danger to public health or safety. To this end, the Performance Improvement Coordinator is organizing a group of multidisciplinary team members to interview doctors, nurses, administrative officers and stakeholders regarding the policy. According to the supplemental report, the VHA expects the full assessment to be completed by December 15, 2007.

### **The Whistleblower's Comments**

Ms. Taylor commented on the initial report and supplemental report. In response to the initial report, Ms. Taylor expressed the opinion that the OMI did not conduct a thorough investigation and they did not request or review all information pertinent to her allegations. She contended that, instead of merely stating that no one provided them with information showing that any patients had been harmed, the OMI should have requested incident reports from the Risk Management Department on all sentinel events that have occurred since the new policy was implemented.

Ms. Taylor also objected to the OMI's conclusion that the two adverse incidents she reported to them had occurred before the AOD position was abolished, and were therefore irrelevant. She stated that, to the contrary, the two incidents in question -- one of which occurred in October 2005 and the other, in December 2005 -- actually took place after the new policy was implemented. Ms. Taylor explained that, although the VAMC issued a memo outlining the reorganization in January 2006, the AOD position had actually been dissolved prior to that time, in September 2005.

Ms. Taylor commented on the OMI's findings regarding the decreased efficiency and staffing flow problems during Code Blues and Code Greens. She observed that "it stands to reason that if the staffing level is critically reduced in a critical care area, then patient care activity will also be reduced to a critical level," thereby creating a danger to public health and safety, especially in Intensive Care Units. Ms. Taylor maintained that the nursing staff has provided the VAMC administration with much negative feedback regarding the new policy, but the administration has ignored their input.

Ms. Taylor lamented the fact that Nurse Managers are not compensated for on-call duty. She asserted,

As managers we work eight long, hard hours. When we leave we get calls on the

way home, when we get home, during dinner, while helping the kids with their homework, when preparing for bed, and while we are sleeping. . . . I definitely feel that some sort of back pay or retribution is in order.

Ms. Taylor noted that, according to the agency report, the Houston VAMC appears to be the only VAMC in its VISN that does not pay its nurses extra for being on-call.

Ms. Taylor also commented on the supplemental report. She stated that the situation at the VAMC has worsened since the OMI team completed its investigation in early 2007. Ms. Taylor advised that six Nurse Managers, including herself, have since stepped down from the Nurse Manager position in order to avoid the extensive on-call duties required under the current policy. In the meantime, the VAMC has had a difficult time finding nurses to replace the Nurse Managers who have departed. She further reported that the turnover rate among Charge Nurses and staff nurses is also extremely high due to low morale.

Ms. Taylor related that, as a result of the low morale and high turnover rate among nursing staff, several units are in complete disarray. For example, Ms. Taylor reported that the Surgical Intensive Care Unit (SICU) lost its Nurse Manager and at least 10 seasoned nurses, which forced the Chief of Staff to shut down four SICU beds. Ms. Taylor contended that, as a result, many veterans have had their surgeries delayed or rescheduled, and now it is common for veterans to have to wait several months before undergoing surgery.

### **The Special Counsel's Comments and Recommendations**

Based on the representations made in the agency reports and Ms. Taylor's comments, I have determined that the agency reports contain all of the information required by statute. Because the agency has agreed to re-evaluate the current policy and has stated that it will consider the policy's potential health and safety ramifications, I have also determined that the agency's findings are reasonable.

Even though I find the agency report to be reasonable, I remain concerned that the current nursing policy could jeopardize the health and safety of veterans. The findings of the investigation clearly demonstrate that the Nursing AOD served a critical role in coordinating patient care functions during off-tour hours. When the VAMC eliminated the AOD position, it left a void in the VAMC's nursing care structure. The measures that the VAMC has put in place thus far to compensate for this loss may not be adequate to guard against a breakdown in the efficiency and morale of the nursing staff. The nurses reported that there is no longer anyone at the VAMC during off-tour hours who can assume a global view of the hospital's staffing needs and reassign nurses accordingly. They contended that, as a result, on several occasions units have experienced severe staffing shortages, especially during emergency Code Blue and Code Green situations.

It is also clear that the current policy has taken a toll on the current staff. The nurses reported significant stress and that they are constantly operating in "crisis mode." As a result, the VAMC has experienced a high turnover rate, and has had difficulty filling the current vacancies. Ms. Taylor reported that many of the units are severely understaffed and are now in

disarray. She and several other witnesses expressed concern that patient care has suffered as a result of these problems.

I am pleased that the agency has agreed, at my request, to re-evaluate the nursing structure and its policy changes. The agency's re-evaluation warrants thoughtful consideration of the health and safety consequences in the restructuring of staffing resources. Although I do not find that the investigative findings are unreasonable within the meaning of 5 U.S.C. § 1213(e)(2)(A), I urge the agency, as I have in other matters involving the restructuring of resources at VA facilities, to take steps to ensure that these organizational efforts do not lead to a compromise in the care provided to our nation's veterans.