



U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

The Special Counsel

February 14, 2024

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

Re: OSC File No. DI-23-000571

Dear Mr. President:

I am forwarding to you a report transmitted to the U.S. Office of Special Counsel (OSC) by the Secretary of Veterans Affairs (VA), in response to the Special Counsel's referral of disclosures of wrongdoing at the Central Virginia VA Health Care System, Richmond VA Medical Center (Richmond VAMC), Richmond, Virginia. The whistleblower, [REDACTED], who consented to the release of her name, is a Machine Operator at the Richmond VAMC Laundry Service. I have reviewed the disclosure, agency report, and whistleblower comments and, in accordance with 5 U.S.C. § 1213(e), have determined that the report contains the information required by statute and the findings appear reasonable.¹ As summarized below, the agency substantiated one of the allegations.

[REDACTED] disclosed that Richmond VAMC Laundry Service employees found used syringes—*i.e.*, contaminated sharps—containing blood or other substances in soiled textiles received from various patient care units. [REDACTED] also disclosed that the Richmond VAMC did not repair leaks in the roof of the building housing the Laundry Service and allowed rainwater to enter and pool in work areas. The report substantiated the first allegation, but not the second.

The Richmond VAMC's Laundry Service sorts and cleans textiles for the Richmond and Hampton, Virginia, VAMCs. The Laundry Service performs two distinct functions in two separate areas. First, employees sort, by hand, soiled linen received from various patient care units, and machine wash these linens in the soiled-linen area. Second, in the clean-linen area, employees dry, press, fold, and then package the clean linens for delivery to patient care units. The Veterans Healthcare Administration's (VHA's) guidance for the Healthcare Environment and Facilities Program is in a draft² *Textile Care Procedure Guide* (VHA Program Guide).

¹ OSC referred the allegations to Secretary of Veterans Affairs Denis McDonough for investigation pursuant to 5 U.S.C. § 1213(c) and (d). The Office of the Medical Inspector investigated the allegations and Secretary McDonough reviewed and signed the agency report.

² The guide is a draft because it has not been formally published, but VHA leadership directed facilities to follow it.

The report substantiated that Laundry Service employees found contaminated sharps and other medical waste in soiled linens, and that risks to employees were not adequately managed. The report noted that the container used by Laundry Service employees to discard the contaminated sharps and medical waste was oftentimes overflowing and that the facility's Infection Control did not make routine rounds in the Laundry Service. The report concluded that the Richmond VAMC failed to provide Laundry Service employees with appropriate protective, Nitro gloves—which violated the VHA's Program Guide and constituted a specific danger to the health and safety of Laundry Service employees. The report determined the Richmond VAMC did not have a written policy or standard operating procedure (SOP) for employees to follow when they find contaminated sharps or medical waste in soiled linens, and as such, the facility did not report or track these occurrences. The report also determined that the current VHA Program Guide did not contain information on the risks of finding sharps in soiled linens or discuss preventative measures. Nor did it provide direction on how to report finding a sharp in soiled linens or being injured by a sharp. Additionally, Laundry Service employees could not reference an SOP to follow and were unfamiliar with the Joint Patient Safety Reporting (JPSR) system. The report also determined that employees did not properly manage lint accumulation in the Laundry Service because they did not clean lint from equipment daily, which also violated the VHA Program Guide.

Consequently, the report recommended that the facility take the following corrective actions: establish a linen cart tracking system to track which patient care units send soiled linens with sharps and medical waste, and then report the tracking results to facility committees; train clinical staff on how to properly dispose of sharps and debris before placing linens in hampers; develop an SOP for reporting sharps and other items found in soiled linens; provide JPSR training to Laundry Service employees; establish a monthly schedule for the Infection Control Service to inspect the Laundry Service; and daily clean lint from laundry equipment that can be reached.³ The report also recommended that the VHA review its draft Program Guide and consider including information about potential risks of finding sharps in soiled linen, preventive measures employees must take, and the process to use to report finding sharps or injuries from sharps.

Regarding the roof, the Laundry Service is underground, partially beneath other building floors and partly under a ground level patio. Small amounts of standing water were seen near machines in the soiled linen area during a site inspection, but no water was seen dripping from the ceiling or running down a wall. However, the Chief of the Engineering Service confirmed that until recently a water stain existed on a wall in the clean area that had developed when it rained—the wall was recently painted. The Richmond VAMC has spent over \$55,000 on roof

³ Additionally, the Laundry Service has consulted with Infection Control on puncture resistant gloves and the facility is working with vendors to provide several Nitro glove options to employees for trial purposes. Also, the Laundry Service's sharps container is now on a schedule and routinely emptied by a third-party contractor.

The President
February 14, 2024
Page 3 of 3

repairs over the last three years and conducted mold remediation in the Laundry Service. Additionally, the report stated that the facility's roof is past its expected lifecycle and fiscal year 2024 funding has been secured to replace it.

In her comments, [REDACTED] expressed appreciation for the investigation's thoroughness. [REDACTED] agreed the facility has acted on several recommendations from the report—including obtaining appropriate protective gloves, providing JPSR training to laundry staff, educating clinical staff about sharps and debris, and establishing a tracking system. [REDACTED] requested the facility provide laundry staff additional in-person trainings on fire safety, blood-borne pathogens, and Occupational Safety and Health.

I thank the whistleblower for bringing these serious allegations to OSC's attention. Her effort has resulted in significant corrective action that will improve the safety of Laundry Service operations. As required by 5 U.S.C. § 1213(e)(3), I have sent copies of this letter, the agency report, and whistleblower comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. I have also filed redacted copies of these documents and the redacted referral letter in our public file, which is available online at www.osc.gov. This matter is now closed.

Respectfully,

A handwritten signature in dark ink that reads "Karen Gorman". The signature is fluid and cursive, with a long horizontal stroke at the end.

Karen Gorman
Acting Special Counsel

Enclosures