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The Special Counsel

November 8, 2017

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

Re: OSC File No. DI-14-2519

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), I am forwarding a report from the Department of Veterans Affairs (VA) based on disclosures of wrongdoing at the Samuel S. Stratton VA Medical Center (VAMC), Albany, New York. Valerie Riviello, a former nurse manager who consented to the release of her name, alleged that in two instances, psychiatrists physically restrained a patient for excessive lengths of time – in one instance for 49 hours – in violation of VA regulations, policies, and rules. She contended that these and other incidents demonstrated a pattern of psychiatrists making determinations to continue or discontinue restraints based on their schedules or convenience, rather than the needs and welfare of the patients. OSC has reviewed the agency report and provides the following summary of the report, whistleblower comments, and OSC's findings.[1]

OSC referred the allegations to former Acting Secretary Sloan D. Gibson for investigation pursuant to 5 U.S.C. §1213 (c) and (d). The Office of the Medical Inspector (OMI) investigated the allegations, and former Chief of Staff Jose D. Riojas was delegated the authority to review and sign the report. On February 11, 2015, the VA submitted the report to OSC. In response to OSC's request for additional information and clarification, the VA submitted supplemental reports on May 5, and November 20, 2015. The whistleblower provided comments in response to each report.

[1] The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, he is required to advise the appropriate agency head of his determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c). Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

I. The Agency's Reports and Whistleblower's Comments

The investigation partially substantiated Ms. Riviello's allegations. OMI found that in one incident in January 2013, the on-call psychiatrist delayed conducting an initial assessment and entering a restraint order for a patient who was restrained by nursing staff, in violation of Joint Commission[2] standards and VA standard operating procedures. In response to the psychiatrist's failure to provide appropriate care to this patient, the VAMC permitted the psychiatrist to retire in lieu of disciplinary action. The investigation also confirmed improper care resulting from an excessive amount of time to replace the endotracheal tube of a patient in a seclusion room. Additionally, OMI found that patient restraint logs were incomplete and lacked entries for restraint episodes; Nursing Restraint Flow Sheets were missing; and the Inpatient Psychiatry Unit did not consistently document patient Interdisciplinary Treatment Plans, in violation of VA rules and Joint Commission standards. The VA concluded that these actions constituted a violation of law, rule, or regulation and a substantial and specific danger to public health and safety.

OMI did not substantiate a pattern of psychiatrists making determinations to continue or discontinue restraint based on their schedules or convenience. For the two specific instances of alleged improper restraint of a patient in November 2013 and February 2014, OMI did not find that the patient was restrained for an excessive length of time. Despite conflicting evidence regarding whether the nursing staff had indicated that the restraints should be removed in both incidents, OMI concluded that the patient had numerous episodes of hostile and agitated behavior and posed a risk to herself and others. For the November 2013 incident, OMI found that Ms. Riviello released the patient from restraints "without proper authority because the policy granting [registered nurses] the authority to release patients from restraints had expired" and the VAMC did not have a local policy in place. OMI similarly concluded that the VAMC did not have a policy or standard operating procedures authorizing registered nurses to initiate restraints in emergencies when there were no psychiatrists on the unit. OMI further found that Ms. Riviello's removal of the restraints, in conflict with the treatment plan, was concerning, "especially since she was not a part of the treatment team and not working on the Inpatient Psychiatry Unit that day."

In response to these conclusions, Ms. Riviello provided the VAMC's Nursing Restraint Minimization Policy, NSG Policy 1-007-12 (May 3, 2012) (Nursing Policy), authorizing registered nurses to discontinue patient restraints. She also provided the VAMC's Nursing Restraint Minimization Standard Operating Procedure, NSG 2-025-12 (May 29, 2012) (Nursing SOP); Amended August 5, 2013), authorizing registered nurses to initiate restraints in an emergency without an order when the provider is not on the unit. Both provisions were in effect at the time of the 2013 and 2014 restraint incidents. OSC notified the VA of these provisions and requested clarification of OMI's

[2] The Joint Commission is an independent, non-profit organization that accredits and certifies health care organizations, including VA medical centers, throughout the United States.

conclusions that the nursing staff lacked authority to initiate and remove restraints because the VAMC did not have a policy in place. OSC also requested that the VA identify the policy and procedures under which the psychiatrists and other providers were authorized to initiate patient restraints.

In its supplemental report, the VA conceded that the VAMC's Nursing Policy and Nursing SOP were in effect at the time of the restraint incidents. The VA still maintained, however, that the VAMC did not have a "Medical Center restraint policy," and did not identify the policy or procedures under which the psychiatrists and other providers were acting, as OSC requested. Further, the VA concluded that, even with the Nursing Policy in effect, Ms. Riviello was not authorized to discontinue the patient's restraints, because the VA interprets the policy to authorize only the nurses and providers on the patient's treatment team to discontinue restraints. The VA stated that, because Ms. Riviello was not the nurse manager for the Inpatient Psychiatry Unit that day, she was not on the patient's treatment team and was not authorized to remove the restraints. In further explaining OMI's findings, however, the supplemental report presented evidence suggesting that Ms. Riviello was the nurse manager in the Inpatient Psychiatry Unit when she discontinued the patient's restraints. The supplemental report did not fully resolve the evidentiary discrepancies presented in the initial report and, in some instances, raised further questions regarding OMI's conclusions. The information also suggests that investigators confused the patient's treatment plan with decisions concerning the use of restraints, which, pursuant to VA regulations and rules, are separate decisions based on emergency situations that require the use of the least restrictive restraint and discontinuation as soon as possible.

Ms. Riviello provided comments on the supplemental report further refuting the VA's findings. She provided documents reflecting that she was on duty and performing her nurse manager and team leader responsibilities in the Inpatient Psychiatric Unit when she discontinued the patient's restraints in November 2013. She further explained that she had cared for this patient extensively during several admissions, was involved with the patient's treatment, and as nurse manager had the authority under the policy to remove the patient from restraints. She also contended that information that she coerced a nurse to remove the patient's restraints in February 2014 was false, noting that she was not on duty during the February 2014 incident and never spoke with the nurse. OSC forwarded Ms. Riviello's comments and accompanying documents to the VA and provided an opportunity for the VA to respond.

The VA provided a second supplemental report, in which it further modified its conclusion, now contending that Ms. Riviello should not have discontinued the restraints because she was not the patient's assigned registered nurse. In response to Ms. Riviello's assertion that the VA falsely reported that she coerced a nurse to remove the restraints in February 2014, the VA discussed only the November 2013 incident and did not discuss or provide any information regarding the February 2014 incident. In addressing OSC's renewed request for the policy and procedures under which the psychiatrists and other

providers were authorized to initiate restraints in 2013 and 2014, the VA referenced the Nursing Policy and Nursing SOP. The VA also cited Network Memorandum No. 10N2-95-09 (June 24, 2009), which is the policy that the VA confirmed had expired in 2012 and did not provide authority to act in the 2013 and 2014 incidents. The VA also cited Memorandum No. SI-118-10, *Restraint and Seclusion Minimization Policy for Acute Medical, Surgical, Behavioral Health Units*, establishing a policy for the VAMC. In light of this policy, it is not clear why the VA maintained that the VAMC did not have a "Medical Center restraint policy."

II. Corrective Actions

In response to the findings, OMI recommended that the VAMC develop and implement a new policy and standard operating procedures governing patient restraint and seclusion, specifying the roles of physicians and nurses. OMI also recommended a root cause analysis of the missing Nursing Restraint Flow Sheets; implementation of a method for electronic documentation of this information; and an audit system for patient restraint logs. OMI further recommended that in facility locations where required equipment is not readily available, patients with medical emergencies should be transferred to the Emergency Department. Additionally, OMI recommended an audit of the Interdisciplinary Treatment Plans of current psychiatric inpatients, as well as an independent review of management practices to determine compliance with VA rules and Joint Commission standards.

The supplemental reports confirmed that the VAMC developed and implemented a new policy and standard operating procedures governing the use of restraints and seclusion in compliance with VA and Joint Commission standards. Importantly, the supplemental reports also confirm that the VAMC has educated staff on these new provisions. The VA further confirmed that the other recommended corrective actions were completed, with ongoing biweekly audits of current patient Interdisciplinary Treatment Plans until management determines that such audits are no longer necessary.

III. Conclusion

OSC has reviewed the original disclosure, the agency reports, and the whistleblower comments. OSC has determined that the reports meet the statutory requirements; however, the findings do not appear reasonable. The reports present conflicting evidence, unresolved discrepancies, and changing rationales that do not fully support the VA's findings regarding the restraint incidents reported. Significantly, the central issues in this case involved patient care, specifically whether treating psychiatrists had complied with VA regulations and rules governing patient restraint. However, the investigation instead focused largely on the actions of the whistleblower. The reports also demonstrate confusion and/or a lack of knowledge of VA rules and policies on the restraint of mental health patients, including the policies and procedures that were in place at the VAMC at the time of the incidents described. Nevertheless, OSC is

encouraged that the VA has taken appropriate corrective action, including the implementation of and training for a revised policy and procedures that are now in place at the VAMC.

As required by 5 U.S.C. § 1213(e)(3), OSC has sent a copy of this letter, an unredacted version of the agency reports, and whistleblower comments to the Chairmen and Ranking Members of the Senate and House Committees on Veterans' Affairs. OSC has also filed a copy of the letter to the President, redacted reports, and whistleblower comments in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,

Henry J. Kerner
Special Counsel

Enclosures