The Honorable Henry Kerner  
Special Counsel  
U.S. Office of Special Counsel  
1730 M Street, NW, Suite 300  
Washington, DC 20036  

Re: Office of Special Counsel File No. DI-23-000571  

Dear Mr. Kerner:

I am responding to your May 23, 2023, letter to the Department of Veterans Affairs (VA) regarding whistleblower allegations that the Richmond VA Healthcare System (hereafter Richmond) located in Richmond, Virginia, may have engaged in conduct that may constitute a violation of law, rule or regulation, and a substantial and specific danger to public health and safety.

The Under Secretary for Health directed the Office of the Medical Inspector to assemble and lead a VA team to investigate. We conducted an unannounced site investigation on this matter July 24, 2023, and a virtual investigation on August 22, 2023.

We substantiate one of the whistleblowers' allegations and do not substantiate one allegation. We make nine recommendations to Richmond, one recommendation to the Veterans Health Administration and one recommendation to Veterans Integrated Services Network 6. The signed report will be sent to the respective offices with a request for an action plan.

Thank you for the opportunity to respond.

Sincerely,

Denis McDonough

Enclosure
DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Report to the
Office of Special Counsel
OSC File Number DI-23-000571

Richmond VA Healthcare System
Richmond, Virginia

Report Date: November 28, 2023
Content Manager: 2023-C-25
Executive Summary

Introduction

The Office of the Secretary of the Department of Veterans Affairs (VA) received a referral from the Office of Special Counsel on May 23, 2023, for a formal resolution. Subsequently, the Under Secretary for Health directed that the Office of the Medical Inspector assemble and lead a VA team to investigate allegations concerning the Central Virginia VA Healthcare System’s medical center (hereafter Richmond), located in Richmond, Virginia. The whistleblower, who consented to the release of their name, alleged conduct that may constitute a violation of law, rule or regulation, and a substantial and specific danger to public health and safety. We conducted an unannounced site visit to Richmond on July 24, 2023, and inspected the entire laundry facility. We conducted virtual interviews with 11 staff members on August 22, 2023.

Specific Allegations of the Whistleblower

1. Richmond VAMC laundry service employees have found used syringes (contaminated sharps) that appear to contain blood or other substances in soiled textiles received from various patient care units.

2. The Richmond VAMC has not repaired leaks in the roof of the building that houses the laundry service allowing rainwater to enter and pool in certain work areas.

We substantiate allegations when the facts and findings support that the alleged events or actions took place and do not substantiate allegations when the facts and findings showed the allegations are unfounded. We are unable to substantiate allegations when the available evidence was insufficient to support conclusions with reasonable certainty about whether the alleged event or action took place. After careful review of the findings, we make the following conclusions and recommendations.

Conclusions for Allegation 1

- We substantiate that Richmond laundry service employees have found used syringes (contaminated sharps) and other medical waste in the soiled linen while they are sorting the linen from various patient care units.

- By not having Nitro gloves with extended cuffs available for use by laundry service staff sorting soiled linen, Richmond is not in compliance with Healthcare Environment and Facilities Program (HEFP), Textile Care Procedure Guide (TCPG) and in this instance, constitutes a specific danger to the health and safety of laundry service employees.
• Richmond does not have a documented policy or standard operating procedure (SOP) that outlines the procedure to follow when sharps or other medical waste is found in the soiled linen area.

• Richmond does not have effective oversight of the problem of sharps found in the soiled linen since they are not formally tracking, trending, or reporting these occurrences.

• Infection Control does not routinely make rounds in the facility.

• Laundry service employees are not completing a full daily blow down of all equipment that they can safely reach to manage lint accumulation, thus they are not in compliance with HEPF's TCPG.

• The Veterans Health Administration (VHA) HEFP current guidance in the TCPG does not include information related to the potential risks of finding sharps in the soiled sorting process and the preventive measures employees must take or the process employees should take to report finding sharps or being harmed by a sharp while sorting soiled linen.

Recommendations to Richmond

1. Verify that all laundry service staff have access to and use the Nitro gloves with extended cuffs and a minimal thickness of 15 mil for use when sorting soiled laundry. Verify that staff use these gloves consistently for staff safety and compliance with HEPF’s TCPG requirement, and address any non-compliance as indicated.

2. Establish linen cart tracking system to be able to determine which location(s) are sending laundry with sharps and other medical waste items to the laundry area.

3. Educate all clinical staff about properly disposing of all sharps found in linen and removing any debris that is on the bed or stretcher before linen is removed and placed in soiled hamper.

4. Develop an SOP for reporting sharps and other items found in linen during the soiled sorting process.

5. Provide Joint Patient Safety Reporting training for all laundry service employees.

6. Track and trend incidents of sharps or other medical waste in soiled laundry area. Monitor and report results to the appropriate facility committee.

7. Establish monthly inspection rounds by the Infection Control Service or Department in the soiled linen area, until incidents of sharps found are resolved.
8. Manage lint accumulation with a full daily blow down of all equipment to be compliant with HEFP’s TCPG requirement.

Recommendation to VHA

1. Review HEFP guidance in the TCPG document. Consider including an overview related to the potential risks of finding sharps in the soiled sorting process, the preventive measures employees must take, and the process employees should follow to report an incident of finding sharps or being harmed by a sharp while sorting soiled linen.

Conclusions for Allegation 2

- We do not substantiate that Richmond has not repaired leaks in the roof of the building that houses the laundry service. However, there is still water pooling from machinery leaks and reported ceiling leaks in the laundry facility.

Recommendation to Richmond

9. Coordinate with Veterans Integrated Services Network (VISN) 6 Industrial Hygiene and Facilities Lead to inspect the laundry facility ceiling to determine source of leaking water. Once determined, formulate and execute a plan to properly repair the areas in the ceiling that are leaking.

Recommendation to VISN 6

1. Provide oversight of the ceiling inspection of Richmond’s laundry facility to determine the source of leaking water and the plan to properly repair the areas in the ceiling that are leaking in Richmond’s the laundry facility.

Summary Statement

We developed this report in consultation with other VHA and VA offices to address the Office of Special Counsel’s concerns that Richmond engaged in conduct that may constitute a violation of law, rule, or regulation; gross mismanagement; abuse or authority; or a substantial and specific danger to the public health or safety. We reviewed the allegations and determined the merits of each, and the National Center for Ethics in Health Care has provided a health care ethics review. We found the Richmond laundry service employees have found used syringes (contaminated sharps) and other medical waste in the soiled linen while they are sorting the linen from various patient care units which does constitute a specific danger to laundry employees sorting soiled linens. We did not find Richmond has not repaired leaks in the roof of the building that houses the laundry service.
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I. Introduction

The Office of the Secretary of the Department of Veterans Affairs (VA) received a referral from the Office of Special Counsel on May 23, 2023, for a formal resolution. Subsequently, the Under Secretary for Health directed that the Office of the Medical Inspector assemble and lead a VA team to investigate allegations concerning the Central Virginia VA Healthcare System’s medical center (hereafter Richmond), located in Richmond, Virginia. The whistleblower, who consented to the release of their name, alleged conduct that may constitute a violation of law, rule or regulation, and a substantial and specific danger to public health and safety. We conducted an unannounced site visit to Richmond on July 24, 2023, and inspected the entire laundry facility. We conducted virtual interviews with 11 staff members on August 22, 2023.

II. Facility Profile

Richmond, part of Veterans Integrated Services Network (VISN) 6, consists of one medical center located in Richmond, Virginia and six community-based outpatient clinics located in Fredericksburg (Southpoint, Massaponax, and Mary Washington locations), Charlottesville, Emporia, and Henrico, Virginia. The Central Virginia catchment area has an estimated population of 200,000 Veterans. Richmond is a 349 operating bed medical center that offers primary, secondary, and tertiary diagnostic and therapeutic health services in medicine, surgery, mental health, dental, neurology, rehabilitation medicine, transitional care, oncology including radiation therapy, acute and chronic spinal cord injury, skilled nursing home care, and palliative care to a primarily adult and geriatric population. The medical center serves as one of the Veterans Health Administration’s (VHA) five Polytrauma Rehabilitation Centers.

III. Specific Allegations of the Whistleblower

1. Richmond VAMC laundry service employees have found used syringes (contaminated sharps) that appear to contain blood or other substances in soiled textiles received from various patient care units.

2. The Richmond VAMC has not repaired leaks in the roof of the building that houses the laundry service allowing rainwater to enter and pool in certain work areas.

IV. Conduct of Investigation

The VA team conducting the investigation consisted of the Medical Inspector and a Clinical Program Manager, both from the Office of the Medical Inspector, and the Acting Deputy Chief, VHA Environmental Program Services who served as subject matter expert (SME). We held a brief meeting with Richmond’s Acting Director and Richmond’s Chief of Environmental Management Services at the end of the site visit.
We held a virtual entrance and exit briefing with the following VISN 6 and Richmond leadership:

- Richmond Acting Director (Associate Director)
- Richmond Associate Director for Patient Care Services
- Richmond Assistant Director
- Richmond Chief, Quality Management
- Richmond Executive Assistant to the Director
- VISN 6 Quality Management Officer

We interviewed the following Richmond employees:

- Fact Finding Investigator
- Infection Control Nurse
- Patient Safety Manager
- Laundry Facility Employees (6)
- Laundry Facility Manager
- Chief, Engineering Service

V. Background, Findings, Conclusions, and Recommendations

Allegation 1

Richmond VAMC laundry service employees have found used syringes (contaminated sharps) that appear to contain blood or other substances in soiled textiles received from various patient care units.

Background

Laundry facilities perform distinct functions in two separate areas: soiled linen sorting and washing on the soiled side; and drying, ironing, folding, and packing on the clean side. Employees working on the soiled side receive used linen from a sending area and hand sort it into bags based on type (sheets, blankets, pajamas, etc.). Once sorted, and depending on delivery needs, they process linens through the washing machine. Employees working on the clean side then dry, press, and fold the textiles before packing for shipment back to a user area. During the pressing and folding process,
laundry workers visually inspect the linens for stains, tears, and overall cleanliness. Linens that fail visual inspection go back to the soiled side where they are re-sorted for either re-washing or recycling (rag out).

The Richmond laundry facility provides textile care services to two sites, Richmond and Hampton VA Medical Centers (VAMC). The Richmond laundry facility was designed to process 5.2 million pounds of textiles annually, operating 5 days per week. Presently, the facility is processing 2.3 million pounds of textiles annually.

Although contaminated textiles and fabrics in health care facilities can be a source of substantial numbers of pathogenic microorganisms, reports of health care associated diseases linked to contaminated fabrics are so few in number that the overall risk of disease transmission during the laundry process is likely negligible. Laundry workers should wear appropriate personal protective equipment including gloves and protective garments while sorting soiled fabrics and textiles.1

The VHA Healthcare Environment and Facilities Programs (HEFP) current guidance is outlined in the draft Textile Care Procedure Guide (TCPG) dated 2022. This guide includes personal protective equipment guidance on the use of Nitrile-type gloves with an American National Standards Institute (ANSI) puncture rating of 2 (on a 0-5 scale), with a minimal thickness of 15 mil and with an extended cuff.2 Part of the procedures outlined in the TCPG includes checking for foreign items such as sharps (syringe needles, scalpels), adhesive tape, trash, pens, and food.3 We noted that the TCPG is posted on the internal HEFP website and that the document is still considered a draft because it has not been formally published. However, VHA HEFP leadership has directed the field to follow guidance contained in the TCPG document.

Findings

On the day of the site visit, the investigative team’s SME immediately noted that the laundry employee sorting the soiled linen was not wearing Nitro gloves (also known as Nitrile-coated gloves) with the extended cuff as recommended by the TCPG. Upon further inspection, the employee was wearing two pairs of standard latex rubber gloves that appeared too small for the employee. We found the recommended Nitro gloves with extended cuff are not available to Richmond laundry employees. Upon follow-up with the laundry manager on August 22, 2023, we learned Richmond is working with vendors to provide several glove options for laundry employees for trial purposes. Additionally, the laundry manager has consulted with the facility Infection Control nurse regarding the need for puncture resistant gloves in the soiled sorting area.

2 1 mil = 1/1000 of an inch.
The investigative team received several undated photographs of visible sharps, syringes, and other disposable equipment contaminated with blood or other fluids and medications in the soiled linen sorting area. Of the six laundry employees we interviewed, four reported finding a variety of medical waste in soiled linens within the last 6-12 months and two employees reported finding such items within 3 weeks prior to their interview with our team. Employees described discarded sterile packaging, unused syringes that are still sealed in packaging, as well as syringes with uncapped needles attached and syringes with liquid or blood content mixed in with soiled linens. Some employees reported witnessing the sharps container they use to discard sharps and syringes overflowing in the laundry area on more than one occasion. At the time of the site visit, staff informed us that the laundry location was not on the regular schedule to have their sharps container emptied. However, at the time of the virtual interviews on August 22, 2023, laundry employees reported that the sharps container is now on a routine schedule that is emptied by a third-party contractor.

The soiled linen from the Hampton VAMC comes in green bins. This is a different color from Richmond’s soiled linen bins. Richmond does not have a tracking system in place to identify the location laundry bins of soiled linen come from within the facility. There is speculation from the many staff interviewed that the soiled linen containing sharps and medical waste comes from Richmond’s operating room. There is no tracking, trending, or reporting of sharps or other medical waste in soiled linen. The Infection Control nurse became aware of the issue of finding sharps in the soiled linen area in April 2022 and shared the information immediately with the Richmond Nurse Manager group. On April 21, 2022, the Infection Control nurse also sent an “Educational Tidbit” email to all clinical staff instructing them to remove any debris that is left on bed or stretcher linens prior to removing the linen.

We also learned that in August 2022 and May 2023, Richmond’s leadership distributed an email to all employees that stated, "In alignment with High Reliability Organization principles, we must support front-line staff and anticipate risks. Please use extra caution with needles, syringes, and any other sharp object to ensure proper disposal in sharps containers. Please do not throw any item that can harm someone into a trash can, and also check the dirty linen as it is being removed from a patient’s room. We must ensure all of our team members are safe and don’t accidentally get injured.”

The laundry employees we interviewed reported being very comfortable reporting safety concerns to their supervisor, but they did voice concern regarding follow-up. Laundry service leadership reported there are daily morning and afternoon huddles with all employees to share information. However, the laundry employees we spoke with indicated they do not receive feedback about the incidents they report. None of the laundry employees were familiar with the Joint Patient Safety Reporting (JPSR) system nor could they reference a policy they follow for reporting sharps or other debris in soiled linen. Richmond does not have a documented policy or standard operating procedure (SOP) that describes what procedure staff should follow when a sharp or other medical waste is found in the soiled linen area and there is no tracking, trending,
or reporting of such incidents. Additionally, we learned that Infection Control nurses are not required to routinely make rounds in the laundry facility.

Upon further review of HEFP guidance outlined in the TCPG, we note that there is no overview related to the potential risks of finding sharps in the soiled sorting process and the preventive measures employees must take. We did not find any reference in the TCPG that describes the process employees should take to report finding sharps or being harmed by a sharp while sorting soiled linen.

During the onsite facility tour, the investigative team's SME noted Richmond laundry service employees were not completing a daily blow-down of all equipment to remove accumulated lint. The TCPG requires the clean side of the laundry plant to be cleaned daily, to include sweeping, mopping, waste removal, blow-down of equipment, and disinfection of surfaces. Surfaces must be cleaned of dirt and debris before they can be properly disinfected. Richmond has a contractor come into the laundry facility every 2 weeks to carry out a thorough blow down of all equipment. However, lint buildup is a fire hazard and employees should be completing a daily blow down of all equipment that they can safely reach as required by the TCPG.  

Conclusions for Allegation 1

- We substantiate that Richmond laundry service employees have found used syringes (contaminated sharps) and other medical waste in the soiled linen while they are sorting the linen from various patient care units.

- By not having Nitro gloves with extended cuffs available for use by laundry service staff sorting soiled linen, Richmond is not in compliance with HEFP’s TCPG and in this instance, constitutes a specific danger to the health and safety of laundry service employees.

- Richmond does not have a documented policy or SOP that outlines the procedure to follow when sharps or other medical waste are found in the soiled linen area.

- Richmond does not have effective oversight of the problem of sharps found in the soiled linen since they are not formally tracking, trending, or reporting these occurrences.

- Infection Control does not routinely make rounds in the facility.

- Laundry service employees are not completing a full daily blow down of all equipment that they can safely reach to manage lint accumulation, thus they are not compliant with HEFP’s TCPG.

4 Ibid.
• VHA’s HEFP current guidance in the TCPG does not include information related to the potential risks of finding sharps in the soiled sorting process and the preventive measures employees must take or the process employees should take to report finding sharps or being harmed by a sharp while sorting soiled linen.

Recommendations to Richmond

1. Verify that all laundry service staff have access to and use the Nitro gloves with extended cuffs and a minimal thickness of 15 mil for use when sorting soiled laundry. Verify that staff use these gloves consistently for staff safety and compliance with HEFP’s TCPG requirement, and address any non-compliance as indicated.

2. Establish linen cart tracking system to be able to determine which location(s) are sending laundry with sharps and other medical waste items to the laundry area.

3. Educate all clinical staff about properly disposing of all sharps found in linen and removing any debris that is on the bed or stretcher before linen is removed and placed in soiled hamper.

4. Develop an SOP for reporting sharps and other items found in linen during the soiled sorting process.

5. Provide JPSR training for all laundry service employees.

6. Track and trend incidents of sharps or other medical waste in soiled laundry area. Monitor and report results to the appropriate facility committee.

7. Establish monthly inspection rounds by the Infection Control Service or Department in the soiled linen area, until incidents of sharps found are resolved.

8. Manage lint accumulation with a full daily blow down of all equipment to be compliant with HEFP’s TCPG requirement.

Recommendation to VHA

1. Review HEFP guidance in the TCPG document. Consider including an overview related to the potential risks of finding sharps in the soiled sorting process, the preventive measures employees must take, and the process employees should follow to report an incident of finding sharps or being harmed by a sharp while sorting soiled linen.

Allegation 2

The Richmond VAMC has not repaired leaks in the roof of the building that houses the laundry service allowing rainwater to enter and pool in certain work areas.
Findings

The laundry service is located underground. We were informed it is partially beneath other building floors and partially beneath a ground level patio. We witnessed small amounts of standing water in the soiled area around some of the machines, but we did not observe any water dripping from the ceiling in the laundry facility.

On June 5-7, 2023, Richmond had an assessment of the laundry facility completed by VHA Central Office HEFP. The assessment report identified several water leaks including on the soiled side of the laundry facility near the recycling system, the tunnel system, the small washers and the dual pump system and heat recovery unit in the mechanical room. VHA’s Central Office HEFP will be following corrective actions regarding the identified leaks.

The laundry services employees interviewed reported there is a wall in the clean area that becomes wet when it rains and a water stain from the ceiling to the floor existed there until it was recently painted. The investigative team did not observe the area the employees referenced during the tour of the facility on July 24, 2023. However, the Chief of Engineering Service corroborated that there was a water stain as described and the Industrial Hygienist coordinated repairs for that issue. The Chief of Engineering Service also shared that the facility roof is past its expected lifecycle and funding has been secured for fiscal year 2024 to replace the facility roof. The investigative team notes there is not a roof directly above the laundry facility and the source of the ceiling leak is unclear.

Richmond has spent over $55,000 for roof repairs over the last 3 years and 4 months. Richmond has also had mold remediation work completed in the laundry facility related to water leaks.

Conclusions for Allegation 2

- We do not substantiate that Richmond has not repaired leaks in the roof of the building that houses the laundry service. However, there is still water pooling from machinery leaks and reported ceiling leaks in the laundry facility.

Recommendations to Richmond

9. Coordinate with VISN 6 Industrial Hygiene and Facilities Lead to inspect the laundry facility ceiling to determine source of leaking water. Once determined, formulate and execute a plan to properly repair the areas in the ceiling that are leaking.

Recommendations to VISN 6

1. Provide oversight of the ceiling inspection of Richmond’s laundry facility to determine the source of leaking water and the plan to properly repair the areas in the ceiling that are leaking in Richmond’s the laundry facility.
Summary Statement

We developed this report in consultation with other VHA and VA offices to address the Office of Special Counsel's concerns that Richmond engaged in conduct that may constitute a violation of law, rule or regulation; gross mismanagement; abuse or authority; or a substantial and specific danger to the public health or safety. We reviewed the allegations and determined the merits of each, and the National Center for Ethics in Health Care has provided a health care ethics review. We found the Richmond laundry service employees have found used syringes (contaminated sharps) and other medical waste in the soiled linen while they are sorting the linen from various patient care units which does constitute a specific danger to laundry employees sorting soiled linens. We did not find Richmond has not repaired leaks in the roof of the building that houses the laundry service.
Attachment A

References

Guidelines for Environmental Infection Control in Health-Care Facilities 2003,
https://www.cdc.gov/infectioncontrol/guidelines/environmental/background/laundry.html.

June 2023.

Richmond Laundry Soiled Side Pictures.

Relevant Richmond Employee Communication Emails.

VHA Healthcare Environment and Facilities Programs, Environmental Programs
Service, Textile Care Procedure Guide 2022,
Attachment B
Example ANSI-Rated Glove

Glove (example only) shown in figure 1 has an ANSI puncture rating of "2". Glove shown is Nitrile coated with a minimum thickness of 15 mil and has an extended cuff as required by guidance contained in the TCPG.

Figure 1 Nitrile-Coated Gloves with Extended Cuff
Attachment C
Investigative Team and Interviewees

Investigative Team Members

- [Redacted], M.D., the Medical Inspector/Medical Investigator
- [Redacted], RN, Clinical Program Manager
- [Redacted], Acting Deputy Chief, VHA Environmental Program Services

Interviewees

- [Redacted], Fact Finding Investigator
- [Redacted], MS, RN, MT (ASCP), Infection Control Nurse
- [Redacted], RN, MSN, CPHQ, Patient Safety Manager

Laundry Facility Employees:

- [Redacted]
- [Redacted]
- [Redacted]
- [Redacted]
- [Redacted]
- [Redacted], Laundry Facility Manager
- [Redacted], MSHA, Chief, Engineering Service
### Attachment D

**List of Acronyms**

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<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>ANSI</td>
<td>American National Standards Institute</td>
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<td>HEFP</td>
<td>Healthcare Environment and Facilities Programs</td>
</tr>
<tr>
<td>JPSR</td>
<td>Joint Patient Safety Reporting</td>
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<tr>
<td>SME</td>
<td>Subject Matter Expert</td>
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<tr>
<td>SOP</td>
<td>standard operating procedure</td>
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<td>TCPG</td>
<td>Textile Care Procedure Guide</td>
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<td>Department of Veterans Affairs</td>
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