U.S. Office of Special Counsel
1730 M Street, N.W., Suite 218
Washington, D.C. 20036-4505

Improper VA Management of Social Work Harmed Veterans, Led to One Man's Leg Amputation

FOR IMMEDIATE RELEASE
CONTACT: Zachary Kurz, (202) 804-7065; zkurz@osc.gov

WASHINGTON, D.C./April 10, 2019 – The U.S. Office of Special Counsel (OSC) today alerted the President and Congress that whistleblowers revealed that management at a U.S. Department of Veterans Affairs (VA) medical center in Indianapolis directed social workers to stop entering home health care consults into a computerized patient record system. Because VA leadership attempted to implement the change without collaborating with key services or allowing time for coordination and education, these visits were not being properly logged, resulting in significant delays in care. As a direct result, one veteran had to have his leg amputated after he was not provided timely wound care.

The agency substantiated the whistleblowers' allegations, finding that the lack of communication surrounding home consults resulted in a system breakdown and significant delays in at least one veteran's care. In June 2017, a veteran was discharged from the medical center after receiving treatment for diabetic ketoacidosis and an ulcerated foot abscess. A home healthcare consult was entered to provide the veteran assistance dressing his foot wound at home. However, the consult was not properly processed, and the veteran did not receive the necessary home health care. The investigation found that the veteran's wound became infected and required below-the-knee amputation due to the delay in receiving dressing changes from a home care agency.

In response to these findings, the medical center updated and implemented the home health care consult standard operating procedures. The medical center has provided training to all key staff members, clarifying that entering home health care consults is within the scope of practice for social workers. In addition, the practice of discontinuing incomplete consults was halted at the medical center; referral nurses now immediately contact the provider or social worker to address the incomplete consult.

"It is unconscionable that after serving his country, a veteran lost his limb not on the battlefield, but because of mistakes made by the agency entrusted to take care of him," said **Special Counsel Henry J. Kerner**. "While I commend the VA for taking the necessary steps to prevent similar problems from occurring in the future, this situation should never have happened."

An external peer review of the veteran who did not receive timely wound care is currently underway.

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The U.S. Office of Special Counsel (OSC) is an independent federal investigative and prosecutorial agency. Our basic authorities come from four federal statutes: The Civil Service Reform Act, the Whistleblower Protection Act, the Hatch Act, and the Uniformed Services Employment & Reemployment Rights Act (USERRA). OSC's primary mission is to safeguard the merit system by protecting federal employees and applicants from prohibited personnel practices, especially reprisal for whistleblowing, and to serve as a safe channel for allegations of wrongdoing. For more information, please visit our website at www.osc.gov.