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The Special Counsel

July 22, 2014

The President
The White House
Washington, D.C. 20510

Re: OSC File No. DI-12-3553

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), enclosed please find agency reports based on disclosures made by a whistleblower at the Department of Health and Human Services, (HHS), Indian Health Service (IHS), Blackfeet Community Hospital (Hospital), Browning, Montana. The whistleblower, Ms. Heather Dawson, a former nurse at the Hospital, alleged that employees engaged in conduct that constituted a violation of law, rule, or regulation, and a substantial and specific danger to public health and safety with respect to patient care and facility security. Ms. Dawson consented to the release of her name.

The agency investigation substantiated that nurses at the Hospital were expected to care for a full unit of patients without adequate clerical support, nursing staff, or supervision. The investigation also found that nurses did not properly complete transfusion tags documenting the patients' status following transfusions. In addition, Hospital doors were routinely propped open and security measures were lax. Hospital staff, patients, and visitors regularly smoked at the non-smoking facility. Finally, the agency determined that multiple exterior and security lights were inoperable and the response from Hospital security was slow, creating a security concern.

In response to the report, IHS issued or re-issued patient care policies, installed a lock and alarm on the security door, repaired lighting, filled all nursing positions with full-time nurses, and improved supervision, revised the smoking policy, and met with the Blackfeet Tribal Health and Blackfeet Tribal Council to request assistance in implementing corrective actions. I have determined that the agency reports contain all of the information required by statute and that the findings appear to be reasonable.

On January 23, 2013, OSC referred Ms. Dawson's allegations to then-Secretary of Health and Human Services Kathleen Sebelius to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d).[1] Secretary Sebelius asked Yvette Roubideaux, MD, MPH, Acting

[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, she is required to advise the appropriate agency

Director of IHS, to conduct the investigation, who in turn requested the assistance of the Office of Healthcare Programs. On July 8, 2013, HHS submitted the agency's report to OSC. In response to OSC's request that certain statutorily required information omitted from the July 8, 2013, report be provided, HHS submitted a revised report dated November 21, 2013. Pursuant to 5 U.S.C. § 1213(e)(1), Ms. Dawson submitted comments on the agency's report on December 16, 2013. At OSC's request, HHS submitted supplemental reports on the status of corrective actions, dated March 5, 2014, and May 16, 2014. Ms. Dawson declined to provide comments on the supplemental report. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the reports and the whistleblower's comments to you.

The Whistleblower's Allegations

Ms. Dawson alleged failures affecting patient care as well as security concerns on the Hospital campus. First, she disclosed that nurses improperly administered drugs to induce sleep so that they could take extended breaks, failed to monitor patients for drug reactions as required, and left patients without care while the nurses slept or watched movies. She also disclosed that Hospital employees propped open security doors to locked patient units, smoked outside the Hospital entrance and permitted patients and visitors to smoke, and failed to adequately maintain exterior lighting on Hospital grounds. Finally, she alleged that security patrols for staff housing were inadequate.

Specifically, Ms. Dawson stated that on numerous occasions during her tenure at the Hospital, she observed nurses failing to attend to their patients. Ms. Dawson worked as a nurse on the inpatient ward, four times a week for overnight, twelve-hour shifts. Ms. Dawson observed nurses sleeping in empty patient beds or the employee break room for several hours at a time. Ms. Dawson specifically cited the behavior of two employees: Certified Nursing Assistant Lissa Flammond, whom Ms. Dawson observed taking extra breaks to sleep on every shift, and Outpatient Nursing Supervisor Jessica Racine, whom Ms. Dawson also confronted for sleeping while on duty multiple times. According to Ms. Dawson, these actions negatively affected patient care.

Ms. Dawson asserted that nurses left patients to go on break immediately after administering medication or blood transfusions, without observing the patient for an allergic reaction for fifteen minutes, as required by Hospital policy. Ms. Dawson also alleged that between July 2011 and March 2012, she overheard two nurses discuss administering unnecessary medication to make patients sleep so that the nurses could go on extended breaks.

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head of her 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) and (g).

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).

Ms. Dawson disclosed that employees propped open the locked unit door leading to the patient wards to avoid having to call staff to open the door after the employees took breaks to smoke outside. The unit door was required to be secured between 9:00 p.m. and 6:00 a.m. to prevent safety risks to staff and patients, as the unit included patients who were mentally ill or undergoing alcohol or drug withdrawal, and prison inmates. She reported that Hospital security closed the doors when they found them propped open, but the practice continued.

Ms. Dawson disclosed that staff, visitors, and patients routinely smoked outside the Hospital entrance during the time she was employed there, in violation of IHS policy. She also noted that nurses took extended smoke breaks while on duty. She was, on one occasion, ordered by a doctor to escort a patient outside to smoke. The IHS Tobacco Free policy prohibits the use of tobacco at all IHS-operated properties.

Finally, Ms. Dawson alleged that IHS did not maintain adequate exterior security lighting on the Hospital grounds and that security in the unlighted staff housing was inadequate to ensure safety. She disclosed that seventy-five percent of the exterior lights were in need of replacement bulbs, and staff housing did not have any exterior lighting. She cited three incidents that occurred in the area of staff housing in which she lived involving thefts from her car and a voyeur. She reported the lighting outages and other incidents, but did not observe improvements in lighting and security.

The Agency's Reports

The agency investigation did not substantiate that nurses were sleeping on duty or watching movies during the night shift, but found evidence that at least one nurse had been cautioned about sleeping. According to the report, the investigators did not receive reports of sleeping or movie watching from non-nursing staff interviewed for the investigation—these staff members were able to observe the inpatient nurses on the night shift. Notwithstanding this finding, the director of nursing conducted unannounced tours of the unit and issued a memorandum to nursing staff on February 19, 2012, and again on June 28, 2013, warning against sleeping and watching movies while on duty. In addition, Ms. Racine, Ms. Dawson's supervisor, also investigated Ms. Dawson's complaints.[2] She issued a verbal warning to Ms. Flammond, who denied that she had been sleeping on duty. The agency report additionally noted that staff observations supported the investigative findings, which were that "nurses were expected to care for a full unit of patients without adequate clerical support, nursing staff, or supervision."

The investigation substantiated that many nurses left the Hospital for their one-hour lunch to go home. The report concluded that this absence could potentially result in a need for assistance from a nurse who was absent from the Hospital premises. This break, coupled with the short staffing and high patient occupancy rates, could lead to instances of unavailable nursing assistance.

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[2] Ms. Racine was identified in the agency report as "Eva" Racine.

The investigation substantiated that nurses' failure to document the patients' status was a significant issue. Several nurses failed to complete the documentation required when administering blood transfusions. In mid-2012, the Quality Assurance Office (QAO) developed a new policy to encourage the completion of the transfusion "tag." Every unit of blood was required to be accompanied by a transfusion tag, and a process of documentation established from the physician's order to the delivery of the treatment. The QAO monitored compliance with the new policy and found "improvement over the old system, but not 100 percent." Nurses failed to complete five percent of the transfusion tags. The QAO reviewed each incomplete tag and worked with the Nursing Department to complete tags prior to permanent filing. Based on these findings, the QAO has instituted one-on-one training for nurses who fail to complete the required documentation, to supplement ongoing training for all nursing staff.

The investigation did not substantiate that nurses administered unnecessary medications to promote sleep so that they could take extended breaks. The investigator and pharmacy employees conducted research into the archived information for the administration of Ativan, an anti-anxiety medication, during the period of July 2011 through March 2012 by the nurses identified in the complaint. The investigation found no evidence that medication was given to promote sleep. The nurses documented the patients' status after each administration of Ativan.

The investigation substantiated that security doors were propped open. An exterior, full glass door with a vestibule, located approximately forty feet from the nurses' station, was propped open by visitors and patients. The door opens directly from the back parking area into the combined nursing unit, which serves inpatients as well as obstetrical and newborn patients. Despite signage on the door advising that anyone wishing to enter after the door was locked at 9:00 p.m. should use the Emergency Room (ER) entrance and be escorted, visitors and family members repeatedly gained access through this door by knocking until the door was opened. Nurses expressed concern to investigators about the lack of a unit access policy and the easy exterior access to the inpatient, obstetrics, and newborn units.

The investigation substantiated that staff, patients, and visitors smoked daily, and that the smell of cigarette smoke came into the unit occasionally. The investigators observed individuals smoking during four out of five visits to the inpatient unit at different times of the day. The report stated that nurses also confirmed that staff, patients, and visitors smoked directly outside the door to the inpatient unit, and that the smell of cigarette smoke came into the unit. The investigators noted many cigarette butts at the ER and main entrances to the Hospital. According to the report, the Hospital chief operating officer stated that prohibiting smoking was difficult "as the 'Tribe' feels this was their Hospital and if they wish to smoke they would smoke." Nevertheless, the report identified a violation of IHS, Division of Epidemiology and Disease Prevention, IHS Tobacco Free Policy § 4.

The investigation substantiated that IHS failed to maintain and repair exterior security lighting. Investigators found that multiple lights, including all four tall light poles

surrounding the front and ER entrances to the Hospital, were off or not working. In addition, ten Hospital-owned street lights adjacent to the driveway to the ER parking area, the ambulance garage, and the rear inpatient parking were inoperable, as were four out of five wall-mounted high intensity lights above the ambulance garage and other doors. One street pole light located by the ER employee entrance was reportedly knocked down two winters ago and was still lying behind the ER. The ER entrance, parking area, and ambulance garage were "essentially black with no adjacent ambient lighting." All lights in the front parking lot and in the housing areas were found to be operable.

The investigation substantiated that Hospital security did not patrol and responded inconsistently, and that security coverage and monitoring capacity was fragmented. The report explained that security is provided as a contracted service from the Blackfeet Tribe, under Public Law 638. Under the contract, the Tribe was responsible for all patrol services of neighborhoods, including IHS government housing. The investigation found that although the Tribal residential treatment program had a comprehensive camera monitoring system with an employee assigned to monitor the cameras, the Hospital lacked such a system. The Hospital complex had eight cameras with no exterior capacity, no zoom, no audio, and no immediate recording capability. Security staff did not have access to the monitoring equipment servers between 4:00 p.m. and 8:00 a.m. for rebooting and/or other technical issues. Only one employee held a key to the office. The security staff also had no access to the internet for the filing of incident reports (known as Webcident reports). According to nurse reports, there was significant variability in response time in calls for assistance to the unit, depending on the security employee on duty. Call response time could be as long as thirty minutes and officers sometimes responded with a "very belligerent attitude."

Corrective Actions

In response to the findings, the Hospital has taken several steps to ensure that staff, patients, and visitors are aware of agency and Hospital policies and practices. With regard to the availability of nursing staff, these steps included: (1) re-issuing a facility memorandum regarding official breaks; (2) developing a policy regarding minimum staffing levels during shift and meal breaks; (3) revising and re-issuing the Nursing Orientation Policy and checklist; and (4) reviewing and re-issuing the Charge Nurse Assignment Policy. The Hospital also re-issued a facility memorandum regarding the prohibition against staff sleeping during duty hours.

To address the finding of inadequate clerical support, nursing staff, or supervision, the agency filled vacant positions and committed to filling other vacancies more quickly. The inpatient ward clerk position was filled and is now scheduled from 8:00 a.m. to 5:00 p.m. Monday through Friday. The change in hours has resulted in an increase in the duties of the ward clerk, according to the report. The consequence is better patient care by the nursing staff. The agency also assigned more experienced nurses to mentor new nurses, filled all nursing positions with full-time nurses, and established guidelines to limit admissions due to staffing levels based on the impact to patient safety. Finally, supervisors have improved lines of communication with staff regarding patient safety issues and to ensure the effective and

efficient quality of care provided to patients.

To address the nursing staff's failure to properly record patient reactions following blood transfusions, the Hospital issued a new policy on blood utilization, and trained all staff involved in the administration of blood products. In addition, the quality assurance nurse now conducts continuous reviews of lab data sheets to ensure compliance with the policy. While the report did not find that nurses administered unnecessary medication to induce sleep in patients, the agency has re-issued two policies to ensure that physicians' orders are followed and to ensure the safe, appropriate, and accurate administration and handling of medication.

The agency has taken action to address the investigative findings that employees routinely propped open security doors. IHS developed a Patient Visitor policy to identify visiting hours, and the Hospital installed a magnetic lock and alarm on the security door. To address the finding that patients, visitors, and employees were smoking on IHS property, the agency revised and implemented a policy reiterating that the facility is a non-smoking campus. Hospital officials held a meeting with the Blackfeet Tribal Health and Blackfeet Tribal Council to request assistance in implementing the policy and informing the public.

The facility took immediate action to repair exterior lighting, and all repairs were completed as of July 31, 2013. According to the supplemental report received on March 5, 2014, the Hospital plans to expand and upgrade the current security and monitoring systems. The planned project will include minor renovations to the present ER access area. Currently in the design phase, the estimated completion date for the project is "late 2014." To address identified deficiencies in the security patrols for the facility, the Hospital plans to meet and re-negotiate the contract to include the government housing, prior to the contract renewal date of October 1, 2014. Currently, tribal security officers patrol the interior and immediate area outside the Hospital on a schedule and route, and officers are available through an electronic paging system. Officers record their patrols on a daily log. Finally, the Hospital installed a data line to the security office and scheduled the installation of a computer to access the Webcident program for March 2014. The facility intends to provide training to security staff on how to utilize the software when access is available.

The Whistleblower's Comments

Ms. Dawson provided comments on the report pursuant to § 1213(e)(1) but declined to provide comments on the supplemental report. She provided corrections to the background and statements that were attributed to her by the investigators, to clarify the record. Notably, she provided further information concerning her licensing and prior employment. With respect to her testimony, she clarified that she did not state that her patient loads were "frequently overwhelming," but rather provided a specific example of a time that she was overloaded and did not receive help from the rest of the staff. Ms. Dawson stated, "The loads were not unfairly assigned; the staff would just refuse to take an assignment, so a shift in loads was necessary." She also corrected a statement attributed to her that a missed dose of medication was "not a big deal," explaining that she actually stated that the missed

medication was "not necessary, per the pediatrician based on the diagnosis of the child." Finally, she explained that she did, understandably, react emotionally after the of a patient. She was reassured by the doctor on the case that she had done everything she could.

The Special Counsel's Findings

I have reviewed the original disclosure, the agency reports, and Ms. Dawson's comments. Based on that review, I have determined that the reports contain all of the information required by statute and that the findings appear to be reasonable.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the agency reports to the Chairmen and Ranking Members of the Senate Committee on Health, Education, Labor, and Pensions and House Committee on Energy and Commerce, as well as the Senate Committee on Indian Affairs. I have also filed copies of the agency reports and Ms. Dawson's comments in OSC's public file, which is available online at www.osc.gov. This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures