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The Special Counsel

July 8, 2015

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

Re: OSC File No. DI-13-4218

Dear Mr. President:

Pursuant to my duties as Special Counsel, enclosed please find the Department of the Army's (Army) investigative report based on disclosures of wrongdoing at the Carl R. Darnall Army Medical Center (Medical Center), Occupational Health Clinic (Clinic), Fort Hood, Texas, made to the Office of Special Counsel (OSC). OSC has reviewed the report and, in accordance with 5 U.S.C. § 1213(e), provides the following summary of the allegations and our findings. The whistleblower, who wished to remain anonymous, disclosed that employees in the Clinic engaged in immunization and charting practices that placed patients at risk and violated agency policies.

The agency substantiated the whistleblower's allegation that Clinic nurses regularly recorded patient immunizations prior to administering them in violation of Army regulations and local policy. The agency also found that some patients may have left the Clinic without receiving required immunizations, but no specific incidents were identified in the investigation, thus the agency could not substantiate this allegation. Similarly, the agency determined that providers do sign charts for patients they do not treat, but that this practice did not violate a law, rule, or regulation. The agency took several corrective actions as a result of its investigation, including additional training for Clinic staff, updates to Clinic policies, and instituting a formal chart review process. I have reviewed the agency's report and the whistleblower's comments, and have determined that the agency's reports contain all the information required by statute and the findings appear to be reasonable.

The whistleblower's allegations were referred to Secretary of the Army John McHugh to conduct an investigation pursuant to 5 U.S.C. § 1213(c) and (d).[1] The matter was then

[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 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. § 213(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

referred to the U.S. Army Medical Command to conduct the investigation. The Secretary delegated the authority to review and sign the agency's report to Acting Assistant Secretary of the Army (Manpower and Reserve Affairs) Karl F. Schneider. The agency submitted its report on the whistleblower's allegations to this office on July 18, 2014. Pursuant to 5 U.S.C. § 1213(e)(1), the whistleblower submitted comments on the agency report on March 9, 2015. As required by 5 U.S.C. § 1213(e)(3), I am now transmitting the reports and whistleblower's comments to you.

I. The Whistleblower's Allegations

The whistleblower alleged that several registered nurses (RNs) at the Clinic chart patient immunizations prior to the immunizations occurring. The charting includes the site of immunization, dose, lot number, and type of medication dispensed. The whistleblower explained that although the RNs chart this information, they do not dispense the immunizations themselves, nor do they escort the patients to the proper room to see the immunization nurse. Rather, the RNs complete the chart and then direct the patient to the immunization room. The whistleblower alleged that patients frequently fail to move on to the immunization room, resulting in a chart that incorrectly reflects that the immunization has been administered. The whistleblower noted that usual practice is to walk the patient to the immunization room without noting the immunization on the chart, and to allow the immunization nurse to chart the administration of the immunization. Concerns about the process were reported to management, including to Col. Jean Dailey, the former deputy chief of Nursing, and Rita Fowler, the chief of Quality Management for the Medical Center, but no action was taken. The whistleblower alleged that this process poses a danger to the health of both patients and the public because of the possibility of infection in patients who are incorrectly recorded as having received immunizations.

The whistleblower also alleged that the physician assistants at the Clinic regularly sign notes in patient charts for patients they never see. The whistleblower noted that the physician assistants generally see only one or two patients a day and that around 98 percent of patients are instead seen by nurses. Patient charts, which are recorded electronically in a system known as the Armed Forces Health Longitudinal Technology Application (AHLTA), have three required signatures: the assigned, or face-to-face, provider, the secondary provider (e.g., the immunization nurse), and the supervisory provider. According to the whistleblower, records for patients who are seen by nurses are transferred to the physician assistants to sign as the assigned provider, despite the fact that the physician assistants never see the patients. In addition, the physician assistants sign as the secondary and supervisory providers. Nurses are not permitted to sign records for the patients they see. The whistleblower noted that in addition to being improper and incorrect, this practice indicates in the patient records that there is no supervisory physician overseeing the physician assistants. The whistleblower stated that physician assistants are generally required, as a condition of licensure, to practice in collaboration with or under the supervision of an appointed physician.

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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).

Pursuant to 42 U.S.C. § 300aa-25(a), a health care provider who administers a vaccine shall record the name and address, and if appropriate, the title of the provider administering the vaccine. Similarly, Army Regulation (AR) 40-562, *Immunizations and Chemoprophylaxis for the Prevention of Infectious Disease*, (October 7, 2013), Ch. 2, Sections 2-7. a.(1) and d.(1) require identification of the person administering the vaccine. Further, AR 40-66, *Medical Record Administration and Healthcare Documentation*, (January 4, 2010), Ch. 3, Section II, 3-4.a. requires that medical record entries must be made by the provider who observes, treats, or cares for the patient at the time of observation, treatment, or care, while Section II, 3-4.c. requires that all entries must be signed or electronically authenticated, and that the first entry must be signed with the first and last name of the person making the entry. In addition, when using AHLTA, as the Clinic does, AR 40-66, Ch. 5, Section I, 5-18 requires that each entry on the patient's form be signed by the person making it.

Based upon the foregoing, the whistleblower alleged that the Clinic's immunization charting practices not only posed a danger to public health and safety, but were also in violation of federal law and agency regulations. The immunization entries being made in patient records do not accurately reflect the name of the provider administering the immunizations and in some cases reflect immunizations that were never administered at all. Further, the whistleblower alleged that the Clinic's practice of having physician assistants sign records for patients they never see is also in violation of agency regulations, which require that the provider who sees the patient makes and signs the entries.

II. The Agency's Report

A. The Findings

The agency found that at least four of the nurses assigned to the Clinic regularly recorded immunizations in patient charts prior to administering the immunizations, also known as "pre-documenting." The agency determined that these actions violated 42 U.S.C. § 300aa-25 and AR 40-66 and AR 40-562, as well as local policy. The investigation found that nurses with a longer tenure in the Clinic tended to be more relaxed with regard to charting, while the newer nurses correctly believed that immunizations should not be charted until after they were administered. The report notes that instances of pre-documentation could result in a negative finding by the Joint Commission.[2] As a result, the agency consulted several Army subject matter experts to determine the significance of the findings. The experts agreed that the nature of the information that was pre-documented and the timing of the pre-documentation in relation to the administration of the immunization would affect the ultimate significance of the wrongdoing. However, the experts determined that in any case, pre-documentation is inappropriate.

[2] The Joint Commission is an independent body responsible for accrediting and certifying health care organizations and programs in the United States.

The agency further determined that immunizations charted by a nurse other than the nurse who administered the immunizations were in violation of AR 40-562. The agency found that the immunization module in AHLTA is specifically designed to be completed by the individual who administers the immunization in order to ensure that any reactions to the immunization can be properly tracked to the manufacturer and the individual who administered it. Nurses who document immunizations without administering them are not engaging in good nursing practice, and may be held liable for any negative patient reactions and could be engaged in fraudulent documentation. Pre-documentation also violates AR 40-66, which requires that the patient's treating completes all documentation, and the spirit of 42 U.S.C. § 300aa-25, which implies that documentation be recorded only if a vaccine is actually given.

The report also notes that the expectations in the Clinic were that each nurse would document the care that they provided to the patient, and no other information, with review and signature by the Clinic's physician assistants and chief. The investigation found that while pre-documentation was not specifically permitted within the Clinic, the Clinic chief was content to permit individual nurses to document as they saw fit, and there was no chart review process in place to identify documentation problems. Thus, the report concludes that the chief was equivocal in his guidance and direction on the matter of pre-documentation.

In addition, the investigation found that the Clinic's licensed vocational nurse (LVN) frequently determined that individual patients did not require all of the immunizations that RNs ordered, which was within her responsibility. However, the LVN did not always notify the RNs of her determination or alter the pre-documented immunizations in AHLTA to reflect the change. Thus, the patient's record could erroneously reflect an immunization that was never given, leaving the patient and the patient's coworkers at risk and susceptible to bacteria and viruses. However, the investigation did not identify any specific instances where the health of a patient or the public was placed at risk due to pre-documentation.

The investigation was unable to determine how frequently patients may have left the Clinic prior to receiving the services that they were ordered to receive. The report notes that several nurses identified patients who were called back to the Clinic because staff were unable to determine if they received all of their required immunizations. One nurse stated that this occurred several times per week; however, the investigation found no evidence of specific patient, unit, or employee harm as a result of the failure to follow proper protocols within the Clinic.

The agency further determined that while physicians regularly sign charts for patients they do not see, this practice does not violate a law, rule, regulation, or Army policy when completed as part of the physicians' supervisory duties. The report states that for charts to reach acceptable coding standards, the privileged provider involved must annotate a significant role in the patient's care. Privileged providers may have oversight and delegation authority over non-privileged providers pursuant to AR 40-68. The investigation determined through a chart review that in the case of the Clinic, while privileged providers did sign charts for patients they did not see, they did so properly in their oversight capacity. The

report indicates that this issue was previously reviewed through a Commander's Inquiry, which determined that the process was correct, but that the findings of that inquiry were not properly explained to all of the nurses within the Clinic. Thus, the agency determined that the Clinic's process for signing and countersigning charts was proper and had been since January 2014.

B. The Corrective Actions

The investigating officer made several recommendations as a result of the investigation, which the commander of the Southern Regional Medical Command ordered to be implemented. The recommendations included: formal counseling for the Clinic chief to remedy ineffective leadership, including training and mentoring; counseling for staff members regarding roles, expectations, and accountability; incorporation of CDC, Military Vaccination, and Advisory Committee on Immunization Practices guidelines into Clinic standard operating procedures and ensure that staff are trained on an and aware of the new procedures; develop a quarterly chart audit for all staff; conduct a review of the immunization module in AHTLA to ensure that all providers are meeting documentation standards; and enact a check-out system to ensure all patients receive the immunizations they require and are properly recorded.

The report also lays out several additional corrective actions that were undertaken as a result of the investigation. For example, the Clinic staff received Judge Advocate training on what constitutes fraudulent medical record documentation and the legal implications of such actions. Management also undertook a review of supervisory relationships within the Clinic to improve communication and overall environment, and provided training opportunities on proper documentation of medical records.

III. The Whistleblower's Comments

The whistleblower took issue with the agency's investigation and findings on the allegation that physicians are improperly signing charts for patients they do not see. Specifically, the whistleblower asserts that in August 2013, Clinic nursing staff were instructed to "transfer" all patient notes, even when the physician assistant did not see or treat the patient, despite nursing staff's request to co-sign notes. When notes are transferred, only the physician assistant's signature remains in the chart. The whistleblower contended that the agency did not satisfactorily investigate this direction.

In addition, the whistleblower noted that a 2013 inquiry into the prior Clinic chief's management style, which is summarized in the report, found that the chief's direction to have physician assistants supervise nurses was inappropriate. The whistleblower posits that if physician assistants are not permitted to supervise nurses, they should also not be permitted to sign patient charts in a supervisory capacity.

IV. The Special Counsel's Findings and Conclusions

The agency conducted a thorough investigation and substantiated two of the whistleblower's three allegations. In response to the investigation's findings, the Clinic undertook a number of corrective actions to ensure that appropriate policies are in place for immunizations and that all staff members are aware of the policies. In addition, counseling was recommended for the employees involved in wrongdoing. While the whistleblower provided valuable comments on the agency's findings and actions, it appears that the agency's review addressed all of the whistleblower's concerns in a satisfactory manner. Therefore, having reviewed the agency's report and the whistleblower's comments, I have determined that the report contains all of the information required by statute and its findings appear to be reasonable.

As required by 5 U.S.C. § 1213(e)(3), I have sent unredacted copies of the agency's report and whistleblower's comments to the Chairs and Ranking Members of the Senate and House Committees on Armed Services. I have also filed copies of the redacted report and whistleblower's comments in our public file, which is now available online at www.osc.gov.[3] This matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosures

[3] The Army provided OSC with a report containing employee names (enclosed), and a redacted report in which employees are identified by title only. The Army cited the Privacy Act of 1974 (Privacy Act) (5 U.S.C. § 552a) as the basis for its redactions to the report produced pursuant to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the report in our public file. OSC objects to the Army's use of the Privacy Act to remove employee names on the basis that the application of the Privacy Act in this manner is overly broad. However, OSC has agreed to post the redacted version of the agency's report as an accommodation.