U.S. Office of Special Counsel
Analysis of Disclosures, Agency Investigation and Report,
and Whistleblower Comments

OSC File No. DI-14-2754
(Carl T. Hayden VAMC, Phoenix, Arizona)

The U.S. Office of Special Counsel (OSC) submits the following analysis and agency reports based on disclosures from Dr. Katherine Mitchell, a physician at the Carl T. Hayden VA Medical Center (Hayden VAMC) in Phoenix, Arizona. Dr. Mitchell's allegations were referred to then-Acting Secretary Sloan D. Gibson to conduct an investigation pursuant to 5 U.S.C. § 1213 (c) and (d). Acting Secretary Gibson directed the Interim Under Secretary for Health to refer the allegations to the Office of the Medical Inspector for investigation. Then-Chief of Staff Jose D. Riojas was delegated the authority to review and sign the report. On December 12, 2014, Mr. Riojas submitted the agency's initial report. On June 19, 2015, Interim Under Secretary for Health Carolyn M. Clancy, MD, submitted a supplemental report. Pursuant to 5 U.S.C. § 1213(e)(1), Dr. Mitchell provided comments to the initial report on January 4, 2015, and to the supplemental report on July 12, 2015.

As required by 5 U.S.C. § 1213(e)(3), OSC has sent copies of the unredacted agency report and Dr. Mitchell's comments to the President and the Chairman and Ranking Members of the Senate and House Committees on Veterans' Affairs. Copies of the redacted agency reports and Dr. Mitchell's comments are also posted in OSC's public file, which is available at www.osc.gov.[1]

I. Dr. Mitchell's Disclosures

Dr. Mitchell worked in the Hayden VAMC Emergency Department (ED) from 2003 until December 2012, and served as the medical director of the department starting in 2009. She disclosed that nurses failed to conduct appropriate triage across multiple service lines, resulting in patient harm. Dr. Mitchell asserted that when patients presented to the ED for care, patients who were not previously enrolled at the Hayden VAMC were sent to the Eligibility Clinic for enrollment before they had a full triage assessment in the ED, in violation of VA policy and community standards of care. Dr. Mitchell further noted that ED nurses were not properly trained to perform triage. She also disclosed deficiencies in the triage process in both the Hayden VAMC Outpatient Ambulatory Care Clinics and Psychiatric Clinic and provided a number of specific incidents where harm resulted from this practice.

Dr. Mitchell also observed numerous instances of patient neglect by ED nurses. She asserted that nurses ignored or refused physicians' orders, did not provide reports, and did not inform treating physicians when patients with possible emergency conditions were ready to be

[1] The VA provided OSC with reports containing employee names (enclosed), and redacted reports in which employees' names were removed. The VA has cited Exemption 6 of the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the reports produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version of the reports in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b), but has agreed to post the redacted version of the reports as an accommodation.

seen. Dr. Mitchell asserted that there was also a systemic problem with mislabeled blood specimens in the ED. She noted that Hayden VAMC policies required labeling vials immediately when blood was drawn at bedside. Instead, ED nurses drew blood and placed unlabeled vials in a container with those of other patients. When the nurses returned to a common area, they would then label all the vials, creating a significant potential for mislabeled specimens.

Dr. Mitchell further noted that the Hayden VAMC lacked on-call vascular lab technicians and ultrasound services. These services were unavailable on Sundays and holiday weekends, and when the designated vascular lab technician was on leave, there was no backup. As a result, when physicians treated patients with suspected deep vein thrombosis, patients were given anticoagulants because vascular lab services were unavailable. In some cases, individuals were treated with these drugs for 72 hours before a vascular lab study was obtained. In addition, Dr. Mitchell stated that in August 2013, she voiced concerns regarding the understaffing of the Hayden VAMC suicide prevention team. She asserted that the team was carrying an extremely high case load and lacked an appropriate number of employees, which reduced its ability to conduct effective outreach and interventions.

Dr. Mitchell also disclosed that the ED lacked current nursing protocols to facilitate expeditious and appropriate patient care. As a result, nurses would not order interventions for patients presenting acute symptoms upon intake. Updated protocols were developed in 2012, but according to Dr. Mitchell these protocols were never distributed to staff. She also disclosed chronic short staffing in the ED, the lab services unit, and suicide prevention teams, which endangered patient safety.

II. The Agency's Report

The agency determined that nurses failed to conduct appropriate triage in the ED and the Psychiatry Clinic. Investigators reviewed cases Dr. Mitchell identified and concluded that these deficiencies constituted a substantial and specific risk to public health and safety. The report noted that despite the availability of a free nationally-recognized curriculum developed to instruct nurses on triage, the Hayden VAMC used a locally-developed program with large content gaps. The report found no evidence of an established training period for nurses to obtain sufficient triage skills. Investigators reviewed the training records of 31 ED nurses and determined that only 11 had completed this training module. The report noted a number of serious near misses resulted from these deficiencies, including a patient with a history of stroke who presented with low blood pressure waited almost eight hours for care. Another patient with a history of recurrent pulmonary embolisms presented with a critically high lab value, which was not properly assessed for eleven hours. Further, an intoxicated patient with tachycardia went unseen for four hours and was never properly recorded in ED systems.

In response, the report recommended that ED nursing leadership adopt the national Emergency Severity Index (ESI) training program for triage nurses, develop a plan for training them, establish performance measures, and require annual refresher training and reviews. The report further recommended a review of training and education records to assess whether nurses have appropriate training and experience necessary to work in the ED.

The agency also substantiated that ED employees were complicit in significant patient neglect. The report noted that nurses failed to perform EKGs when ordered, and failed to follow physician orders for serious patient complaints such as chest pain. Investigators further determined that labeling errors occurred in the ED due to poor adherence to Hayden VAMC policy. The report recommended the establishment of a local performance metric for ED nurses on the timeliness of procedures, and a performance metric on proper specimen labeling procedures to eliminate processing errors.

The report further substantiated that there were significant nurse and physician staffing issues in the ED, but noted that these concerns have been resolved with the acquisition of fee-basis providers and improved scheduling. The report also explained that the Hayden VAMC lacked an on-call vascular lab tech and ultrasound services in violation of VA policy, and this deficiency posed a risk to public health and safety. In response, the report recommended the Hayden VAMC take immediate measures to provide 24 hour vascular service coverage, including on weekends. The report acknowledged that there were also staffing shortages on the suicide prevention team; however, these issues have been resolved with the hiring of four new social workers to lighten caseloads. The investigation did not substantiate that there were staffing shortages in the laboratory services unit but noted concerns related to specimen transport times.

The agency did not substantiate that the Hayden VAMC lacked current nursing protocols. The report explained that from 2003 to 2012, when Dr. Mitchell worked in the ED, many local policies and protocols did not exist; however, the Hayden VAMC provided evidence indicating that it has recently established local protocols and has been following national policies for protocol orders.

III. Dr. Mitchell's Comments

Dr. Mitchell provided extensive comments on the agency's report. She identified a number of areas where the report incompletely addressed patient care issues, or mischaracterized important facts. She noted that "unexplored patient care issues will likely have a detrimental effect on the health of our Veterans at the [Hayden VAMC]," and urged a continued investigation.

Dr. Mitchell noted that notwithstanding the determination that many ED triage nurses were grossly unqualified, there was no recommendation to expedite training or remove unqualified ED nurses from these positions. She emphasized that despite identifying serious issues in the ED, no disciplinary actions were recommended to punish individual employees or managers who compromised patient safety due to their negligence. She further asserted that the investigative team failed to investigate 22 of 33 additional patient neglect examples that she provided, and failed to document conclusions concerning the 11 cases that were investigated. Dr. Mitchell observed that the agency did not make any recommendation for addressing the potentially life-threatening lack of sufficient cardiac monitoring in the ED, despite acknowledging that "the need for a monitored [cardiac telemetry] bed exceeds the ED's capacity to provide it." She also noted that the report failed to address the policy of sending ill, unenrolled

veterans to the Eligibility Clinic to enroll prior to having triage in the ED. While the report recommended training enrollment staff to recognize serious conditions, it did not suggest ending this practice.

Dr. Mitchell stated that the report did not thoroughly investigate whether verbal nursing reports and/or EKGs were withheld from her and explained that she reviewed the witness list provided with the report and observed that a number of key individuals, who could have corroborated her allegations, were not interviewed. Finally, she noted that the report referenced specific violations of VA and VHA policy, but neglected to enumerate the nature of the specific violations, and whether any disciplinary action was taken. Based on these comments, OSC requested a supplemental report addressing these concerns.

IV. The Agency's Supplemental Report

The supplemental report noted that the ED nurse manager immediately removed unqualified nurses from triage, and restricted nurses from triage duties until competencies were assessed. The agency further explained that many of the ED nurses at issue in the original referral were replaced with qualified experienced ED nurses. The supplemental report stated that ESI training was also expedited, and 32 of the 33 ED nurses have now been trained. Notably, the VA provided additional information indicating that despite the above-referenced deficiencies, no disciplinary actions were warranted because managers made "faithful efforts" to execute their responsibilities.

The agency explained that investigators received and reviewed an additional 110 clinical scenarios Dr. Mitchell provided and found that these instances demonstrated improper triage and delays in care. However, the supplemental report noted that because Dr. Mitchell provided appropriate care when she finally saw the patients, no veteran "suffered morbidity or mortality as a result of the [deficient] nursing triage." The agency also noted that the ED had acquired additional cardiac telemetry monitoring beds, and stated that no ED patients were sent to enrollment prior to being seen by a provider.

In response to Dr. Mitchell's assertion that investigators did not interview key witnesses, the supplemental report noted that upon returning to the Hayden VAMC, relevant staff Dr. Mitchell identified were interviewed. The agency also addressed policy violations, noting that the failure to have vascular lab services on-call was a violation of VHA's *Emergency Medicine Handbook.* Nevertheless, the supplemental report acknowledged that no disciplinary action was taken in response to this violation. The agency noted that fee based services were used to minimize risk, and two new technicians have been hired. Thus, the agency determined that managers took appropriate actions to minimize risks while the lab has been staffed to provide additional coverage.

V. Dr. Mitchell's Supplemental Comments

Dr. Mitchell asserted that the recommendations the agency implemented were not sufficient to appropriately protect patient health and safety, given the serious nature of

wrongdoing identified. She noted that the 110 patient episodes referenced above should have been considered near misses or sentinel events, and the ESI training implemented does not sufficiently prepare nurses to identify complex conditions. In addition, she noted that several nurses who neglected patients and compromised patient safety are still actively working in the Hayden VAMC ED. Dr. Mitchell also observed that this lack of accountability has a chilling effect "on physician willingness to call attention to those ED nursing care problems which are still present today." Further, Dr. Mitchell maintained that investigators did not ask appropriate questions of witnesses in a deliberate effort to obscure key facts.