

December 31, 2014

The Honorable Carolyn Lerner
Special Counsel
U.S. Office of Special Counsel
1730 M Street, NW, Suite 300
Washington, D.C. 20036

RE: OSC File No. DI-13-2754

Dear Ms. Lerner:

I have reviewed the unredacted Report to the Office of Special Counsel OSC File Number DI-14-2754. While most of my allegations were substantiated, I am deeply troubled by the glaring deficiencies in the report. The report contains contradictory statements, significant errors in basic facts, and gaps in logic. I have outlined my concerns in the attached document.

It remains unclear why OMI team unexpectedly declined to comment on 33 additional cases I provided. Those cases would have clearly exposed the depth and breadth of the poor nursing care and the need for extensive remediation to adequately address the problems.

It appears that the OMI team did not initiate any serious inquiry to establish whether or not there were significant patient care triage issues in the Ambulatory Care Clinics. Based on its witness list and its own self-described investigation, the OMI team simply concluded my allegation was unsubstantiated without ever interviewing key personnel in the Ambulatory Care Clinics who could have provided information on substandard nursing triage there.

I am appalled that the OMI investigative team wrote that I had the responsibility for developing Emergency Department nursing triage protocols. Blaming the physician whistleblower for the lack of ED nursing triage policy is at best incompetent and, at worst, retaliatory. Such gross mischaracterization of obvious facts also reflects the lack of due diligence the team displayed multiple times during the investigation.

The scope of practice for physicians is separate and distinct from nursing's scope of practice. The responsibility for developing such nursing protocols has always rested squarely in nursing's purview. As dictated by common sense and long-standing Phoenix VA policy & practice, all nursing protocols were to be developed by the Phoenix VA staff nurses and nursing chain of command. There is a Phoenix VA nursing committee dedicated to nursing practice and policy development that also has the responsibility for approving such protocols. As evidenced by emails in my possession, Phoenix VA nursing service assumed the responsibility for developing

those Emergency Department nursing triage protocols. The OMI team did not try to ascertain the truth by interviewing me on this particular issue. I certainly would have provided the emails if I had known that Phoenix VA nursing administrators were trying to make me the scapegoat for their own ineptitude.

When I settled with the VA, I was promised that there would be an investigation into all aspects of my complaint. The patient care issues were incompletely addressed and thus left several issues unresolved. In addition, those who perpetrated the retaliation both at the front line level and along the various administrative chains were never investigated by the OMI team nor have they been investigated to any great degree by the VA Crisis Team charged with addressing my allegations of retaliation.

Overall, the VA investigation into the retaliation I experienced has been poorly managed by the VA. When a VA Crisis Team came to Phoenix to conduct an investigation into the retaliation against me, I did not receive notice of its presence until after the team left town. Despite having ample time to make the necessary travel arrangements, the team never contacted me in advance to notify me of its plan to visit Phoenix. Although I was interviewed via teleconference shortly afterwards, I was shocked when the team members told me the investigation was almost over. I asked them how it could be over if they had never asked me to identify witnesses who could corroborate my statements. The team members didn't answer my question but agreed to take my witness list.

I subsequently provided a detailed witness list in August 2014 to the VA Crisis Team. The list outlined exactly what each witness could corroborate. However, after I recently spoke with several of the key employees I named on my witness list, I learned none of them were ever interviewed about the retaliation against me. If the VA Crisis Team neglected to interview my key witnesses, I strongly suspect that none of my witnesses were ever interviewed as part of the VA's investigation into retaliation. To the best of my knowledge, it also appears that none of the ED nurses who deliberately impeded my care for ill Veterans have ever been investigated.

Based on the above, I have no confidence that the VA has either the capability or true desire to fully investigate the retaliation against me from Phoenix VA ED nurses or facility administrators. Failure to interview any of my witnesses in the matter of the retaliation is strong evidence for the VA's lack of candor in this matter.

I would request that the OSC not close the file on my claim but rather push for an appropriate investigation into the retaliation and unexplored patient care issues in this matter. If the VA is allowed to get away with substandard investigative techniques in such a clear-cut case, there is absolutely no chance that any unscrupulous VA administrator or unprofessional VA employee will be held appropriately accountable for all of his or her actions. Most importantly, unexplored

patient care issues will likely continue to have a detrimental effect on the health of our Veterans at the Phoenix VA Medical Center.

Sincerely,

Katherine L. Mitchell, M.D.

OMI Investigation Report to the OSC: Key Omissions & Factual Errors

There are multiple key omissions and factual errors within the OMI report to the OSC regarding OSC File Number DI-14-2754. The following summary outlines the most egregious of those deficiencies.

- 1. The OMI team failed to investigate 22 of 33 additional cases that were provided to them by the whistleblower and neglected to document its conclusions regarding the 11 cases it did investigate.**

Those additional cases were provided by me in order to illustrate the widespread patient care/triage deficiencies in the Phoenix VA Emergency Department. Those cases represented a wide variety of poor care situations including delayed nursing care, inappropriate care, inappropriate triage, and delay in fulfilling physician orders.

On page 7 of its report, the OMI acknowledged receiving the cases by stating “The whistleblower sent additional documents to VA on September 2, 2014, and an email on September 14, 2014, in which she cited another 33 records for us to review.”

The OMI’s erroneously implied that I did not identify the patients in all 33 additional records when it made the statement “We reviewed 11 of the 33 records – those patients whom the whistleblower could identify – examining the nursing notes, ancillary notes, laboratory values, radiology reports, and physician notes for each patient.” (OSC Report, p. 7) I provided all appropriate patient identifiers on each additional case as well as specified the issue of concern for all additional patients I identified.

Although the purpose of the investigation was to closely examine patient care issues, the OMI team neglected to document any conclusions for the 11 additional cases it stated were investigated. The OMI also failed to provide any explanation as to why it declined to investigate 22 remaining additional cases. The clinical implications of those additional cases are tremendous. If the OMI team would have examined and commented on all the additional cases, it would have exposed the depth and breadth of the poor nursing care and the need for extensive remediation to adequately address the problems.

- 2. While noting that the training qualifications of many Phoenix VA Emergency Department [ED] triage nurses are grossly inadequate and not in keeping with the Emergency Nurses Association guidelines, the OMI fails to make any practical recommendation to expedite the immediate training of Phoenix VA ED nurses or the**

removal from triage of any unqualified ED nurses. Failure to recommend the expedited training and/or the removal from triage of inexperience/untrained nurses means that patient health and safety in the ED will continue to be jeopardized until such training is complete.

On page 5 of its report, the OMI team noted significant lapses in the education and training of triage nurses in the Phoenix VA Emergency Department. It observed that it “found no evidence of an established length of time for nurses to obtain triage education and skills, nor did we find a time requirement for ‘on-the-job training and classroom work,’ before they are assigned triage duties.” (OSC Report, p. 5) It also noted that “One ED nurse reported that she frequently sees patients in the waiting room when they should have been attended to.” (OSC Report, p. 5) This indicates inappropriate triage is still occurring at the Phoenix VA ED.

Although it did recommend that the facility adopt basic triage training, such a recommendation is, by its very nature, a slow process. Since the OMI team established that the care lapses in the Phoenix VA ED triage “constitute a significant risk to public health and safety” (OSC Report, p. 9), the team should have made an urgent recommendation to prevent any nurse inadequately trained in triage from serving in the triage position. Based on the above, the OMI team should have recommended an immediate review of triage skills/training for every nurse and the subsequent removal from triage for any nurse that did not meet the basic training requirements endorsed by the Emergency Nurses Association. Although they may occupy other ED nurse positions, those inexperience and/or inadequately trained nurses should not occupy a triage position until they have completed the required training.

3. The OMI inexplicably blamed the physician whistle-blower for the lack of Phoenix VA ED nursing triage protocols even though the responsibility for such policy has always been within the Phoenix VA nursing chain of command.

On page 10 of its report, the OMI team reported “In 2011 the ED Lean Systems Redesign team made recommendations to improve the ED. It identified the need to develop comprehensive triage protocols.” While the former statement was accurate, the OMI team then inexplicably stated “The whistleblower was responsible for this task.” This statement is inaccurate and inflammatory. I spent years trying to improve the quality of services in the ED. While I could make suggestions on existing nursing protocols, Phoenix VA nursing service administration and existing policies and practice prevented me from creating ED nursing triage protocols.

Blaming the physician whistleblower for the lack of Emergency Department (ED) nursing triage protocols was, at best, incompetent and, at worst, retaliatory. Such gross mischaracterization of

obvious facts also reflected the lack of due diligence the team displayed multiple times during the investigation.

The scope of practice for physicians is separate and distinct from nursing's scope of practice. The responsibility for developing such nursing protocols has always rested squarely in nursing's purview. Those of us in medicine service have never been responsible for creating nursing protocols at the Phoenix VA Medical Center. As dictated by common sense and Phoenix VA procedure, all nursing protocols were to be developed by the Phoenix VA staff nurses and nursing chain of command. There is a nursing committee exclusively dedicated to nursing practice and policy development which also had the responsibility approving & implementing such protocols.

The Phoenix VA nursing chain of command declined for unknown reasons to develop appropriate protocols during the time I was in the Emergency Department. As a physician, I could only make suggestions for change when I saw nursing protocols that were not in keeping with community standards and/or actual practice. I tried to encourage the nursing chain of command to update the protocols when I suggested changes to the existing nursing protocols in 2012. My attempts were ignored by the Phoenix VA senior nursing chain of command. I was never given the responsibility for developing or implementing any ED nursing protocols.

The OMI team neglected to accurately ascertain the individuals who were designated to write the ED nursing protocols. With even minimal inquiry, the team would have discovered that ED nursing management and a group of ED staff nurses took on the responsibility for developing protocols as well as inquiring into community nursing protocols already in existence which might be adopted by the Phoenix VA ED. The times I tried to press the nursing command to produce such protocols, I was thwarted by the former senior nursing command.

As per the 5/14/12 email about ED Clinical Practice Protocols from Nancy Clafin, former senior nursing chain of command, "...We [nursing service] are going to be looking at examples [of triage protocols] from other facilities that we may be able to modify to use..." (Exhibit A) Per that same exhibit, I asked Dr. Clafin (Ph.D. in nursing - not a medical doctor) if she had "...an estimated timeframe for release of at least the preliminary practice protocols that don't go beyond the scope of a nurse's license..." Nursing service did not produce those protocols despite an obvious need for such protocols based on the repeated actual and potential near-misses in the ED related to nursing triage mistakes.

The Phoenix VA has long been aware of the need for standardized nurse triage training in its ED. Per the ED Lean Team Core Meeting minutes of 3/31/11, "...Discussion held regarding the need for formal triage training for all ED nursing staff. Marilyn Tabamo [then employed as the ED

nurse manager] to research availability of such training to include basics/core triage problems found in adult ED patients.” (Exhibit B)

Nursing service has always been in charge of developing and approving nursing protocols at the Phoenix VA. Even as early as February 2009, when I identified a nursing policy that was jeopardizing Veteran lives, I did not have the power to change it. I instead had to go through nursing service. As evidenced by Exhibit C, I sent an email to the facility’s senior nursing chain of command including Dr. Cynthia McCormack (Ph.D. in nursing – not a medical doctor). Her written response stated “...I will ask the nurse folks to take a look at this and address policy/procedure as appropriate...” As per the email string of that same exhibit, I had to send another email in April 2009 because the nursing service’s Evidence Based Practice Review Committee had not addressed the issue in the 2 months since I had first notified nursing service of the life-threatening, substandard nursing policy.

Of special note, on page 10 of the OSC report, the former ED nursing manager asserted that I was unavailable for meetings to discuss protocols. Without delving into motivations why nursing service administration would make such a patently false statement, I would like to reiterate that I was always “on duty” when it came to ED administrative work regardless of my clinical tour of duty. I attended almost all daytime Lean Team meetings and completed almost 100% of my administrative duties on my off-time because physician staffing was so short that I usually had to spend all of my duty hours performing direct patient care. Over the years I was in the ED, I participated in numerous projects, teams, and committees on my off-duty hours whenever I was asked and would never have refused to participate in something as important as ED nursing protocols had I been asked to do so. Nursing service did not ask for my assistance.

4. The OMI did not initiate any inquiry to establish whether or not there were significant patient care issues with triage in the Ambulatory Care Clinics.

The OMI reported “VA substantiates that a nurse failed to conduct appropriate triage in the Psychiatry Clinic (MH) but not in the Ambulatory Care Clinics (PC).” (OSC Report, p. ii) According to its witness list, the OMI team did not interview any ambulatory care nurses or ambulatory care physicians. A lack of due diligence is clearly shown by the team based on its failure to do a basic interview of at least a sampling of ambulatory care front-line staff to determine if my allegations could be substantiated.

There never has been standardized training for Phoenix VA ambulatory care nurses who perform triage in the ambulatory “primary” care clinics. Unfortunately, the issues of poor quality triage found in the Phoenix VA Emergency Department are also mirrored in the primary care clinics. This would have been readily evident if the OMI team had bothered to scratch the surface when

evaluating the ambulatory care clinics. Interviews with ambulatory care physicians would have revealed reports of multiple instances of poor nursing triage in that department.

5. OMI neglected to enumerate the specific violations of VA & VHA policy which were only generically referenced in the executive summary of the report.

The OMI wrote “VA found violations of VA and VHA policy.” (OSC Report, p. v) Despite stating the presence of violations in its executive summary, the OMI failed to specify in the body of its report the nature and extent of the specific violations. With transparency ostensibly the goal of the investigation, it is inconceivable that the OMI declined to elaborate on such important matters. It remains unclear if the few policy violations mentioned in the body of the report encompass all the violations or only illustrate a bare minimum of violations that were discovered by the team.

6. The OMI failed to exercise due diligence when it stated ED Information System [EDIS] board data was present without determining if that EDIS board data was accurate. In truth, the EDIS was grossly inaccurate because it frequently was not updated by the nursing staff. Because EDIS data was often flawed, verbal patient reports were vital to the whistleblower to determine the presence and status of patients.

On page 7 of its report, the OMI referred to “...patient movement was displayed on the ED Information System throughout the department, and that all members of the care team had access to this information”. That sentence falsely implies there was no need to inform me when patients were transferred into rooms. The OMI team did not clarify this issue with me nor did they ask my colleagues in the ED about the state of EDIS accuracy.

Had the OMI asked me, I would have explained that the ED Information System board is manually changed by nursing staff and is only accurate when the nursing staff bother to update the data. There is no automatic updating of EDIS entries. Frequently nursing staff did not update EDIS so that patient location and provider assignment were often inaccurate.

When I was on duty, certain nursing staff would not make any changes in patient location on the EDIS board so it would appear that the patient was still in the lobby. Often I would also find that multiple patients who had not been assigned to me were suddenly assigned en masse while I was otherwise involved with a time-consuming, critically ill patient. As per Exhibit D the inaccuracy of EDIS board information was so prevalent that it resulted in massive daily confusion regarding patient status and location.

7. The OMI team also declined to perform any true investigation to determine if verbal nursing report and/or EKGs were withheld from the whistleblower.

The OMI also failed to make any serious inquiry into the presence or absence of verbal nursing report for my patients. The OMI wrote “Because there are no written records in the EHR of verbal reports, there is no evidence available to either prove or disprove the whistleblower’s statement that nurses did not provide verbal report.” (OSC Report, p. 7)

My ED colleagues as well as several ED nursing staff could have testified that they witnessed multiple episodes where other ED nurses neglected to provide verbal report to me, hand me EKGs, or provide basic care for my patients. However, per my co-workers who were interviewed by the OMI, those types of questions were not part of the OMI inquiry for reasons that are unclear to me.

When a patient is placed in a room, the nursing assessment is completed and vital signs are collected. This information must be communicated to a physician. This is especially important because it enables the physician to assess whether a patient is more ill than expected and thus needs to be seen prior to any other patients. In addition, because initial ED triage was so inaccurate for many years, the exact status of a patient was difficult to determine based on the presenting complaint listed in a few words on the EDIS board. It was standard, routine practice in the Phoenix VA ED for the nurse assigned to a patient room to give the physician verbal nursing report on the patient. Unfortunately, a small group of nursing staff consistently refused to provide nursing report to me although all other physicians received verbal nursing report. There were many of my co-workers in the ED who witnessed nurses failing to give me verbal report or other information.

To avoid having a delay in EKG review and thus a delay in discovering potentially lethal cardiac complications, the standard practice in the Phoenix VA ED was for the nurse to hand the physician the EKG immediately so it could be interpreted without delay. EKGs and verbal reports were routinely withheld from me by a small group of nurses so I could not determine the true status of a patient easily. When the ED was overwhelmed with patients, this severely restricted my ability to prioritize the order in which I would assess patients. Without the nursing information, I could not easily determine who was the sickest in the group of patients in the rooms. Exhibit E is an email I sent to the ED head nurse in April 2012 wherein I described examples of extremely unprofessional and unsafe nursing behaviors that jeopardized patient safety.

8. OMI inappropriately recommended standardized training for the clerical staff to recognize symptoms requiring immediate nursing attention.

One of the OMI recommendations is to “Provide standardized training for the clerical staff who work in the ED to familiarize them with symptoms that require immediate nursing attention, including when to use a dedicated telephone line to contact a triage nurse rapidly.” (OSC report, p. iii)

The clerical staff are not health care personnel. They do not have the background to reliably evaluate symptoms to determine the urgency of referral to a triage nurse. Other than in urgent situations that a lay person would consider an emergency, the staff should not serve as the “safety net” to expedite referral to triage for an ill person presenting to the emergency department. For good reason, serving in such a capacity clearly lies outside the parameters of their expected job duties.

Ill Veterans who seek ED care do not come to be screened by a clerical worker with no health care background. Veterans presenting for care in the emergency department should be screened initially by a trained triage nurse while the clerical staff enrolls the individual simultaneously. It is against community standards, Joint Commission on Hospital Accreditation guidelines, the American Nurses Association, the American College of Emergency Physicians, and common sense to have a clerical worker be the first person with whom an ill person interacts when presenting to an emergency room for care. On page 5 of its report, the OMI even wrote “Both the American College of Emergency Physicians and the Joint Commission recommend that emergency patients should be seen initially by a triage nurse and/or taken directly to a treatment room if an examination area is available, as patients may not know whether or not their symptoms represent an emergency or urgent condition.” It is unclear why the OMI contradicted its own fact-finding when it recommended non-nursing personnel be the first to “screen” ED patients presenting for care.

Until 2013 there was a hot spot triage nurse at the Phoenix VA Emergency Department counter with the clerk or administrative officer of the day “AOD” who could enroll Veterans into the system. That initial triage nurse would evaluate the patient’s symptoms to determine how quickly the patient should be seen while the clerk/AOD would simultaneously enroll the patient.

The Phoenix VA Medical Center should follow the mandated and logical standard of care to have a triage nurse see the patient first or while the patient is simultaneously enrolled by administrative staff.

- 9. OMI incorrectly stated that ED process since 2009 has been to have a patient seen by a clerical worker first prior to seeing a triage nurse. From approximately 2009 through 2012, a triage nurse was actually available at the ED window to evaluate patients immediately in “hot spot triage” while a clerical staff enrolled them simultaneously.**

“Upon presenting to the Medical Center’s ED, Veterans are initially seen by a clerical worker who...registers them and then passes them on to an RN. This process has been in practice since 2009. (OSC Report, p. 4) Unfortunately, this statement is not accurate.

From approximately 2009 through 2012 in the Phoenix VA Emergency Department there was a “hot spot triage” nurse position with a registered nurse who would initially greet patients, evaluate symptoms, and determine how soon the patient should be seen. The hot spot triage nurse would also monitor patients in the waiting room and watch for any changes in condition. Shortly after I was removed from the Emergency Department this “hot spot triage” nurse position was eliminated.

The OMI team easily could have established the existence of a “hot spot triage” nurse if it had queried any Phoenix VA Emergency Department physician, any Phoenix VA ED nurse, any ED Administrative Officer of the Day, or me.

- 10. OMI investigative team failed to interview key witnesses.**

Based on the witness list on page 2 of the report, no ambulatory care physicians, police officers, or administrative officers of the day (AOD) were interviewed. Although page 5 of the OSC report indicated an Emergency Department nurse was interviewed, there were no such nurses listed on the witness list. Several of the individuals whom the OMI included on the witness list were the very same employees who were directly responsible for the retaliation against me. It is incomprehensible that the OMI team would take their statements at face value and not seek any clarification of facts nor follow-up with me. Those unscrupulous employees would have reason not to be forthcoming in their answers to the OMI team. Unfortunately, almost all of the potential witnesses who could corroborate my statements and detail the extent of the patient care deficiencies were never interviewed by the OMI team for reasons that remain unclear.

- 11. The OMI failed to address the unsafe policy of sending ill, unenrolled Veterans to Eligibility Clinic to enroll prior to having triage in the ER.**

For many years there was an Administrative Officer of the Day (AOD) on duty 24 hours a day in the ED. The AOD had the ability to do a limited registration for all new patients while they were being triaged. After I was removed from the Emergency Department, this practice changed. I was told the AOD was removed from day shift purportedly because of an AOD staffing shortage in 2013. Since that time, Veterans new to the VA have been sent to the Eligibility Clinic to enroll prior to receiving an ED nurse triage evaluation unless that Veteran appeared to be in dire distress.

As the OMI team acknowledged in its own report, “patients may not know whether their symptoms represent an emergent or urgent condition”. (OSC Report, p. 5) In addition, patients with serious medical conditions may not appear outwardly ill. Therefore, relying on an administrative worker with no health background to judge whether or not a patient needs to be seen immediately by triage is a dangerous practice.

If the Veteran has never been seen before at the Phoenix VA, being sent to Eligibility Clinic to initially enroll at the Phoenix VA is a waiting process that may take hours. Again, it is against community standards and JCAHO regulations to send a patient presenting for ED care to another section of the facility to see clerical workers to enroll prior to receiving nursing triage evaluation.

12. The OMI overlooked making any recommendation for addressing the potentially life-threatening lack of sufficient cardiac monitoring in the Phoenix VA Emergency Department.

On page 6 of its report, the OMI wrote “At times, the need for a monitored [cardiac telemetry] bed exceeds the ED’s capacity to provide it.” This simple statement has potentially life-threatening implications. A monitored bed is a bed wherein cardiac telemetry “heart monitoring” is done. Patients who require cardiac telemetry monitoring potentially are quite ill. To deny cardiac monitoring to a patient because of lack of bed space can allow potentially life-threatening events to occur unnoticed in an unmonitored patient. The OMI should have recommended increasing cardiac telemetry monitoring capacity in the ED. Failure to make this recommendation is to remain oblivious to one of the more serious patient care dangers in the Emergency Department. It is only a matter of time before a patient who is denied cardiac monitoring or who is transferred out of a bed with cardiac monitoring has a bad outcome.

The OMI made other safety recommendations in its report. Recommendations for increasing cardiac monitoring/telemetry capacity unexpectedly were absent.

13. The OMI incorrectly stated that the nurses prior to 2013 were not allowed to order lab tests or initiate treatments. In truth, the “Clinical Practice Protocols for Ambulatory Care Registered Nurses” were in place for years and allowed Phoenix ED nurses to initiate both lab tests and basic interventions. The OMI even mentions the presence of such protocols in a different section of its report.

Exhibit F contains the Clinical Practice Protocols for Ambulatory Care Registered Nurses that was in place from March 2006 through March 2009 and with the next revision updated to last through March 2012. These protocols were used by nurses throughout the facility including the ED. The presence of such protocols could have been easily ascertained if the OMI team would have interviewed key ED nurses or ED physician staff.

On page 10 of the OSC report, the OMI inaccurately stated that the nurses had used Mosby’s Nursing Consult online. This was not used by triage nurses during 2009-2012. On page 10, the OMI team wrote “The whistleblower also alleged that nurses would not initiate protocol order entries for serious complaints.” The statement implies that I was asking nurses to perform duties outside the scope of their practice or follow protocols that were not in place. This is not accurate. The Clinical Practice Protocols for Ambulatory Care Registered Nurses were in place, facility-approved, and actively used by Phoenix VA Emergency Department nurses. Those protocols allowed nurses to initiate the orders based on certain parameters outlined in the Phoenix VA-approved protocols. A small group of nurses would decline to initiate even basic orders allowed by the protocols such as labs, oxygen or telemetry monitoring for my patients but would do such basic interventions for the patients of other ED physicians. I never asked nurses to perform intervention outside the scope of the protocols or outside the scope of their practice.

On page 10, the OMI even mentions “...the whistleblower had made some changes to the Medical Center’s triage protocols for ED RNs, these new protocols were not implemented until several months after the whistleblower had left the ED.” While appropriately acknowledging the existence of such protocols in 2012, the OMI team erred when it said I “made” changes and that the final protocols were not active until 2013. As per Exhibit A, I suggested changes but did not have the power to make them because the protocols could only be altered via nursing service approval. Those protocols for which I made suggestions were valid through March 2012. Although I do not possess a copy of protocols that were updated after March 2012, those protocols were updated by nursing service in 2012 and were the basis for ED nursing triage interventions for the entire year of 2012. It is grossly inaccurate to state that the ED nursing protocols were not in effect until 2013.

14. The OMI chose not to make any effort to determine the circumstances in the case of the patient who developed a significant abnormal heart rhythm which the floating nurse did not detect.

At the time the event occurred, the hospital would cover nursing shortages in the Emergency Department by sending inexperienced “float” nurses from other wards. The OMI wrote “...because she [whistleblower] was not able to provide patient identifiers, VA was unable to investigate this case.” (p 13) The OMI team did not even attempt to verify the event. One of the ED physicians who witnessed the event could have corroborated my statements.

15. The OMI team declined to initiate even basic inquiry into the allegations of long hours that the whistleblower worked as a condition of her continued employment as the Medical Director of the Emergency Department.

The HR administrator interviewed, according to the witness list, is the same individual who issued the edict that I could be forced to work unlimited hours. Based on the list of those interviewed, the OMI team did not interview the witness who could corroborate my statements and who was at the meeting where I was told I had to work unlimited hours.

During the time I worked the long hours I was in charge of the schedule. According to what was explained to me by both a former physician administrator and a human resource specialist, I had to fill in all the vacancies without compensation or ask my colleagues to do so without compensation. Failure to do so meant loss of my VA position.

When the Administrative Officer took over the schedule, I still had to fill in any gaps in the schedule so I routinely worked more than 40 scheduled hours during short months. I provided the OMI team with the schedules that I had from 2011 & 2012 with the remainder to be supplemented by the VA. The excessive hours I worked were documented clearly throughout those 2 years.

16. The OMI failed to exercise common sense when it naively accepted the Chief of Staff's & Risk Management's wildly inaccurate assertions that the cases I presented to them were “based on expectations of nurses initiating orders which were exceed the scope of their practice”. In truth, the cases I provided all dealt with dangerous lapses in nursing triage in various areas of the medical center.

Phoenix VA administration is blatantly falsifying the nature of the cases I presented for review. The cases I presented for review dealt with dangerously inaccurate nursing triage that had either with actual or potential life-threatening consequences including death. As a physician and former nurse, I am well aware of the scope of practice for both professions.

The Risk Management department has spent years overlooking significant cases that were presented to them. Despite having cases that should have triggered massive red flags/initiated changes to ensure the Veterans were receiving the standard of health care, the Risk Management department repeatedly and consistently ignored the serious cases that have been presented to them, including the ones that I provided.

Although it declined to investigate all 33 additional cases I gave them, the OMI team reviewing just a few of the cases I submitted had serious concerns about the quality of ED triage care provided. The OMI team wrote that it substantiated that ED nurses "...failed to conduct appropriate triage in the ED...These practices constitute a significant risk to public health and safety." (OSC Report, p. 9) There is absolutely no reason to believe that I would submit frivolous cases to either the Chief of Staff or Risk Management. If the OMI had chosen to interview my colleagues in the ED who gave me many of the cases to report, it would have had discovered the gravity of the actual bad outcomes and potential near-misses in triage nursing care.

17. The OMI glossed over the staffing shortages on the Suicide Prevention Team and neglected to mention that efforts to address the shortage did not start till after the Phoenix VA scandal broke.

As per my email to S. Helman and D. Deering dated April 10, 2014, the Phoenix VA administration did not address the critical staffing shortages on the Suicide Prevention Team that had been present for 5+ months at the time of the email. (Exhibit G) Changes to staffing for the Suicide Prevention Team did not occur until after the Phoenix VA scandal came out in the news. I am concerned that the facility administration is still is not addressing the other issues involved in the trend of increasing suicide cases at the Phoenix VA Medical Center. My concerns are based upon the fact that those administrators staffed the Suicide Prevention Team appropriately only after media attention focused on the VA scandal and not because such staffing was the right thing to do for our Veterans to reduce the risk of future suicides.

Exhibit A

Mitchell, Katherine L.

From: Claflin, Nancy
Sent: Wednesday, May 16, 2012 4:06 PM
To: [REDACTED]; Mitchell, Katherine L.
Cc: [REDACTED]
Subject: RE: ED Clinical Practice Protocols.

Dr. Mitchell,

We will get those out to you and the other physicians to review as soon as possible. We need to be sure that we are not approving protocols that go beyond the scope of an RN's license. Thanks for your feedback.

From: [REDACTED]
Sent: Wednesday, May 16, 2012 3:28 PM
To: Mitchell, Katherine L.; Claflin, Nancy
Cc: [REDACTED]
Subject: RE: ED Clinical Practice Protocols.

The format/changes for these protocols cite references that are no longer valid to use as references from the Lippincott nursing site.

* **From:** Mitchell, Katherine L.
Sent: Wednesday, May 16, 2012 8:09 AM
To: Claflin, Nancy
Cc: [REDACTED]
Subject: RE: ED Clinical Practice Protocols.

Dr. Claflin,

* Do you have an estimated timeframe for release of at least the preliminary practice protocols that don't go beyond the scope of a nurse's license? It remains extremely difficult for the physician, especially on busy nights, to write most/all orders for every patient that presents to the ED.

From: Claflin, Nancy
Sent: Monday, May 14, 2012 7:29 AM
To: Mitchell, Katherine L.
Cc: [REDACTED]
Subject: RE: ED Clinical Practice Protocols.

Dr. Mitchell,

Nursing has some concerns about some things that may be beyond the scope of a nurse's license, so we are going to review these closely, and will send out a revision. Nurses can't diagnose, as you know, so we need to look carefully at that. We are going to be looking at examples from other facilities that we may be able to modify to use that will clearly differentiate between assessing and diagnosing. Thanks for the information about physicians; I'll send the revisions to Rickie to send to the physicians when they're ready so we have documented agreement from each physician when we're ready to move forward.

From: Mitchell, Katherine L.
Sent: Monday, May 14, 2012 2:27 AM

Exhibit B

ED Lean Team Core Meeting: 3/31/11

Attendance:

Kate Mitchell, MD, ED

[REDACTED] AOD

[REDACTED] EMS

[REDACTED] HAS

Marilyn Tabamo, RN, ED

[REDACTED]

Ray Chung COS

[REDACTED], MD, ED

[REDACTED], MD, ED

Discussion Items

1. Initial meeting for "core" Lean Team.
2. Review of current issues including need for full-time MSA & full-time EMD. With budget constraints, team should focus on process change in current environment, not on obtaining FTE at this point.
3. [REDACTED] stated he would examine ways to maximize availability of EMD staff in ED both on short & long term basis.
4. Dr. Chung proposes separate HAS meeting (comprised of Dr. Chung, [REDACTED], & [REDACTED]) to discuss current HAS MSA issue with ED currently assigned only half-time MSA at present.
5. Discussion held regarding methods of assigning patients in ED to maximize efficiency. "Common pile" versus "individual assignment". Benefits and drawbacks discussed.
6. Discussion held regarding need for formal triage training for all ED nursing staff. Marilyn Tabamo to research availability of such training to include basics/core triage problems found in adult ED patients.

Mitchell, Katherine L.

From:
Sent: Monday, April 11, 2011 8:22 AM
To: Mitchell, Katherine L., [REDACTED]
Cc: [REDACTED], Chung, Raymond; [REDACTED]
Subject: FW: ED Core Team meeting minutes of 3/31/11
Attachments: ED Lean Team Core Meeting.doc

Thank you Dr. Mitchell

[REDACTED], MBA
Office of the Director, System Redesign Coordinator
Phoenix VA Health Care System
650 E Indian School Rd.
Phoenix, AZ 85012
602-604-3919
Christine.Hollingsworth@va.gov

From: Mitchell, Katherine L.
Sent: Monday, April 11, 2011 7:54 AM
To:
Subject: ED Core Team meeting minutes of 3/31/11

Meeting was cancelled last week.
Attached are the meeting minutes for the first meeting on 3/31/11.

Exhibit C

MailMan message for MITCHELL, KATHERINE L PHYSICIAN
Printed at PHOENIX.MED.VA.GOV [REDACTED]@15:26
Subj: Request for URGENT nursing policy review [#53293724] 02/23/09@16:32 48 lines
From: MITCHELL, KATHERINE L 7 of 7 responses read. In 'ED' basket. Page 1

I believe the Phoenix VA medical center currently fails to meet the community/national standard for the initial emergency treatment of life-threatening hyperkalemia in patients admitted to general medical & surgical wards.

As you are aware, high levels of serum potassium can cause the sudden onset of life-threatening arrhythmias/cardiopulmonary arrest. An EKG has never been a reliable predictor of risk for developing arrhythmias/code arrest in such hyperkalemia. Up to 50% of patients with moderate-to-severe hyperkalemia may have "normal"/benign EKGs. However, at ANY time these patients may develop the same sudden hyperkalemia-induced code arrest as those hyperkalemic patients with abnormal EKGs.

The most common initial intervention for bedside treatment of (verified) mod-severe hyperkalemia is the immediate one-time bolus administration of regular insulin 10 units intravenously followed by the administration of one amp of D50W. This rapid intervention is commonly done by registered nurses across the nation in public/private hospitals.

Unfortunately the intravenous administration of regular insulin is only allowed in the ICUs/telemetry units at our VA hospital. As a result, the ward RNs are not allowed to administer the potentially life-saving bolus intravenous medication. This vitally important therapy is only given AFTER the pt is transferred to telemetry/ICU -- a process that can be lengthy.

Last week a clinical situation arose wherein I learned that one-time bolus intravenous insulin is not allowed to be given on the general wards under any circumstances for moderate to severe hyperkalemia.

The failure to allow immediate one-time intravenous bolus of insulin/D50W to patients on the general medical/surgical wards results in the unnecessary, potentially fatal delay in treatment for our seriously hyperkalemic veterans.

Although the resident physician theoretically could administer the regular insulin intravenously on any ward, requiring the resident to do so can also cause an unnecessary delay in treatment. This is because the residents/interns may be involved in another critical situation or may not be in house. The "search" for the right resident would result in potential significant delays.

1) MCCORMACK, CYNTHIA A 02/24/09@14:04 4 lines

It would, of course, be most helpful if rather than a dramatic, uninformed pronouncement, you talked with nurse folks and a patient centered solution is developed. I will ask the nurse folks to take a look at this and address policy/procedure as appropriate.

2) [REDACTED] 02/24/09@15:12 6 lines

Dr. McCormack, thank you for forwarding this for further consideration, I will follow up with [REDACTED] for an Evidenced Based Practice Review as well as review with [REDACTED] for any changes we may want to consider/make to nursing practice. *

[REDACTED]

3) MITCHELL, KATHERINE L 02/24/09@21:51 51 lines

Thank you for forwarding this issue to the individuals you feel are most appropriate to address the issue.

The purpose of this limited recipient email was to communicate with key individuals in affected service lines including nursing who have the training & skills to not only recognize the seriousness of the situation, but also who have the ability within the VA administration to "fast track" review of this issue.

The specifics of the clinical situation I faced with the hyperkalemic patient were not described in my message because those details were not needed to highlight the urgency of my request.

By not including those details in my email, I perhaps failed to effectively communicate how close the VA came to having this situation end tragically in the death of this patient.

The elevation of potassium was critical in this elderly, bedridden, confused patient who on arrival to our facility had multiple acute medical issues including dehydration, acute renal failure, cellulitis, and pneumonia. His potential for having sudden cardiac arrest from this degree of hyperkalemia was very high. The current policies delayed the administration of IV insulin/D50W for this veteran and needlessly placed his life at risk. Those same policies will needlessly place at risk the lives of other seriously hyperkalemia veterans in the future.

Please be assured that my email was not a "dramatic, uninformed pronouncement". Because I have worked as both an R.N. & an M.D at the Phoenix VA, I have great professional respect for my nursing and physician colleagues in this facility. I would never waste your time with trivial matters.

Before my email was written, I reviewed current Phoenix VA policy, spoke with a Phoenix VA intensivist, discussed the issue with another senior nurse administrator here, contacted several physician colleagues at Banner Health to determine if practice standards had changed on this issue, and informally surveyed several RNs who practice at local hospitals. My statements are accurate.

After consulting with one of the administrators here, I was told the best way to quickly communicate the issue was via email to the key individuals in affected service lines. I did not write this in PKI because I knew the message would need to be forwarded by the original recipients to appropriate individual(s) whom they designated to address the issue.

I certainly never intended to "slight" any recipient/service department

with my email. I apologize if my actions in this matter of offended any of you. I want to keep the lines of communication open.

4) [REDACTED] 02/25/09@10:37 14 lines

Dr Mitchell is correct wrt the hyperkalemia issue. The lack of a policy that reflects national standards reflects poorly on this institution. Hyperkalemia is not a new thing, the policy should have been in place to allow the intervention. WE can fix it now, but it may be wise to review other policies we have in case similar issues.

I don't think it is wise to criticise

the messenger Dr Mitchell for bringing this up, as she worked around the policy at the time to avoid a potential death. She should be credited for doing so

I will bring up this issue at the special care committee

5) MITCHELL, KATHERINE L 04/14/09@19:29 35 lines

I realize that the Evidence Based Practice Review Committee meets only quarterly with the next meeting on 4/16/09.

The outcome of the Phx VA's policy review on bolus IV insulin will impact every clinician's ability to provide rapid life-saving interventions for hospitalized patients with significant hyperkalemia.

After inquiring into the status of the review last week, I was asked to discuss the issue further with a representative of the Evidenced Based Practice Review Committee.

During the informal meeting earlier today, I learned there are some potentially major stumbling blocks to a "fast track" review of the Phoenix VA nursing policy on IV insulin bolus for the treatment of (verified) mod-severe hyperkalemia in hospitalized patients who are not already on telemetry or in the ICU.

Concerns expressed about a change in the IV insulin policy seemed to be in terms of potential for negative patient outcomes from:

- a) side effect of IV insulin (e.g. insulin-induced hypoglycemia),
- b) inappropriate treatment of hyperkalemia in a setting with no cardiac monitoring available, and
- c) inappropriately utilizing emergent resources for a clinical condition for which a small delay in treatment up to an hour would pose no significant clinical problems, especially in those ESRD patients who may "tolerate" higher potassium levels without difficulty.

Although critically analyzing our policy/procedures is important to ensure the adherence to the standards of care, there is no real validity the concerns about IV insulin bolus administration in the setting of significant hyperkalemia.

I believe that

Exhibit D

Mitchell, Katherine L.

From: Mitchell, Katherine L.
Sent: Thursday, January 03, 2013 4:05 PM
To: Felicetta, James; Deering, Darren
Subject: ED Issues for Transition

Because I was told last month that I should not be involved in ED affairs, I don't want to cause any political issues for myself.

However, the EDIS documentation I have highlights many of the common ED issues that must be addressed on by oncoming management staff. (I wrote the 11/21/12 summary as an overview to help Dr. Felicetta understand the ED patient care issues since he was taking over Dr. Piatt's role in the ED. I did not include documentation with that summary because I thought I could give it to Dr. Felicetta in a future meeting as ED director.)

Because I believe this documentation is important, I just delivered a handwritten summary along with 35 pages of documentation in a secure envelope to both your offices.

The documentation consists of EDIS print-outs with comments that show many of the issues in the ED such as: long delays for initial triage, patients never removed from EDIS who subsequently triggered unnecessary 6 hour wait flags, prolonged blocking of beds waiting for admission to wards, wrong patient documentation, and other issues. EDIS print-outs during any 24 hour period in 2012 would show at least 1, if not more, of those issues.

Subj: Breakdown of Communication [#66713022] 04/01/12@13:29 47 lines
From: MITCHELL, KATHERINE L In 'IN' basket. Page 1

Exhibit E

The ED was acutely saturated with high acuity patients on 3/30 & 3/31/12-4/1/12. Multiple issues arose where nursing staff was acutely busy with multiple orders and faced lack of support services. In such situations, the tension level among the staff can peak and staff communication can break down amid the frenzy of activity.

Email that Dr. Mitchell sent to the ED head nurse.

However, in such situations, it is vital to patient care/safety that professional communication lines be kept open among the nurses and between the nurses and physicians. I am concerned because on 3/30/12 and most notably on 3/31/12 in evening/nights vital information was not communicated to me by multiple nurses on evening/night shifts. Issues included 5 different ekgs being dropped on my computer while I was not at counter, patient assignments being changed on EDIS to me by nursing staff without telling me, nurses not informing me when potentially ill patients were put in rooms, & nursing staff not giving me any significant report on patients other than the "EKG was done for chest pain...". In addition, there were multiple instances where the patient name was not updated in EDIS so I couldn't tell who was in a room.

The ekgs should never be left on a desk even if the physician has to briefly be pulled out of a room.

Although switching patients in EDIS to the oncoming physician is appropriate in saturated conditions, the physician must be notified instead of "discovering it" unexpectedly when looking at EDIS for another reason.

Nurse triage information is of vital assistance to the physician to determine order of patient care needed when the ED is saturated with multiple patients.

Yesterday, miscommunication of patient identity by a nurse resulted in the wrong patient receiving IV contrast studies in CT.

I know that the nurses involved when I was on duty [REDACTED] must have been very stressed because of overwhelming numbers of patients. However, lack of communication could have easily resulted in potentially dangerous situations. Would you please emphasize to staff the importance of the above issues?

In addition, a situation occurred last night where [REDACTED] inappropriately made an ESI "4" into an ESI "2" and then proceeded to tell me at the nurses station that I was inappropriately ignoring a level 2. I need to speak with you further on this issue for several reasons including that the nurses in ED must be aware of ESI levels.

Exhibit F

CARL T. HAYDEN
VA MEDICAL CENTER
PHOENIX, ARIZONA

AMBULATORY CARE POLICY NO. 46
MARCH 2006

CLINICAL PRACTICE PROTOCOLS FOR AMBULATORY CARE REGISTERED NURSES

1. **PURPOSE:** To define clinical interventions Ambulatory Care Registered Professional Nurses may initiate when patients present with defined symptoms or complaints.

2. **POLICY:** Ambulatory Care Registered Nurses may, after a nursing assessment has been obtained, initiate diagnostic, referral and preventive measures without direct physician order, to expedite patient care in accordance with approved protocols and Medical Center standards, guidelines, policy and procedure.

3. **PROCEDURE:** Ambulatory Care Registered Nurses may independently initiate (or direct others to initiate) clinical interventions for the defined presenting symptoms or complaint parameters.

PRESENTING SYMPTOM OR COMPLAINT	PARAMETERS OF SYMPTOM OR COMPLAINT	INTERVENTION OPTIONS
Chest Pain	Any of the following cardiac symptoms: <ol style="list-style-type: none"> a. Central / Substernal Compression or Crushing chest pain (band-like, constricting, burning, heaviness, cramping or aching sensation) b. Epigastric pain, non traumatic in origin c. Nausea + / or Vomiting d. Radiating pain in neck, jaw, shoulders, back, 1 or both arms e. Sweating or Diaphoresis f. History of cardiac event g. Irregular heart rate h. Dizziness + / or Weakness i. Shortness of Breath, Dyspnea 	Electrocardiogram within 10 minutes of arrival. Cardiac monitor O2 @ 2-4 liters per nasal cannula Intravenous access CBC Lipase / Amylase Chem 7 or I-STAT LFT / CPK Troponin I PT / PTT / INR O2 Sat. CXR POC Troponin (LSU)
Abdominal Pain /		Initiate NPO Intravenous access CBC w/ DIFF Lipase Amylase Chem 7 or I-STAT LFT CPK UA 3-way abd xray if emesis or distended

PRESENTING SYMPTOM OR COMPLAINT	PARAMETERS OF SYMPTOMS OR COMPLAINT	INTERVENTION OPTIONS
Increased Dyspnea / Painful inspiration or expiration	<ul style="list-style-type: none"> a. Cyanosis, pale, grey face, clammy skin b. Feeling of suffocation c. Frothy pink or copious white sputum d. Decreased level of consciousness e. Severe SOB w/ sudden onset f. Hx of PE, blood clots or lung collapse g. Hx of asthma, not relieved w/ inhaler h. O2 Sat. <90% 	CXR O2 Sat. ABG (before O2) O2 @ 2-4 liters per nasal cannula EKG CBC CPK POC Troponin Blood Cultures X 2 Admission panel INR / PT / PTT Intravenous access
Productive Cough / Congestion / Fever	<ul style="list-style-type: none"> a. Sudden SOB, rapid respirations or Wheezing 	CXR O2 Sat. O2 @ 2-4 liters per nasal cannula Intravenous access Chem 14 CBC w/ diff. Blood Culture X2
Unexplained Bruising / Bleeding	Currently on anticoagulation therapy	PT PTT INR
Hemoptysis	Blood in sputum	Employee PPE / Mask Mask patient O2 Sat. CXR CBC / PT/ PTT INR Sputum Culture Sputum AFB stain

PRESENTING SYMPTOM OR COMPLAINT	PARAMETERS OF SYMPTOM OR COMPLAINT	INTERVENTION OPTIONS
GI Bleed Sx	Hematemesis Black tarry, mahogany stool Lightheaded	Intravenous access CBC PT/PTT LFT Type and Screen
Orthostatic	Change of systolic blood pressure > 20 mm Increase in pulse of 20 beats/min.	Intravenous access CBC Chem 7
Active seizure	Sudden flexion spasm of the head, neck and trunk and extension of arms and legs. With or without loss of consciousness	Intravenous access Anticonvulsant level (if prescribed)
Healed wound w/ Sutures or staples – to be removed Non-diabetic Non-obese patient	Sutures intact 7 –10 days Incision intact No drainage, swelling, redness No fever Documented suture/staple removal date Documented lack of DT vaccine	Suture / staple removal DT vaccine if necessary
Bladder distension	Lack of voiding / dribbling > 8 hours	Urinary cath UA UA C&S KUB
Urinary Difficulty	Any of the following urinary conditions: a. Hematuria b. Flank pain c. Suprapubic pain d. Frequency e. Dysuria f. Shaking chills g. Testicular pain h. Nocturia i. Small frequent voidings j. Abdominal or back trauma	UA UA C&S CBC Blood cultures X2 KUB
Obvious or Suspected Fracture Of Extremity	Unevaluated trauma to extremity Sudden onset in change of ROM Extremity deformity	Immobilize Xray of affected extremity

PRESENTING SYMPTOM OR COMPLAINT	PARAMETERS OF SYMPTOM OR COMPLAINT	INTERVENTION OPTIONS
Probable Foot Infection	Any of the following conditions: Diabetes Mellitus Peripheral Vascular Disease Neuropathy Geriatric 70+	Podiatry consult X-ray affected foot
Functional Foot Problem	Any of the following conditions: Limited ability to ambulate, not associated with systemic disease. Foot pain Foot injury	Podiatry consult X-ray affected foot
Weight Change	BMI < 19 BMI > 27	Nutrition consult
Skin Wound	Break in skin integrity within 72 hours. Documented lack of DT	DT (as necessary)
Newly Diagnosed Diabetic	Diagnosis documented by Physician or mid-level provider.	Hgb A1C @3 and 6 months Diabetic UA Nutrition consult Eye consult Diabetic teaching class referral Podiatry consult
Possible TB Exposure or State required screening	Request from residential care, day care or nursing home. Request from Social Worker for residential care, day care or nursing home placement.	PPD skin test CXR
Visual Change	Any of the following conditions: Recent visual change History Diabetes	Snelling Vision Test Diabetic Eye Exam Referral
Oncology / Chemotherapy Patients	Presents to Oncology Clinic for treatment. Requests will be entered by Ambulatory Care Oncology Clinic staff only	CBC CHEM 7 Calcium LFT Transfusion Request
Oxygen Testing / High Altitude	Presents to Show Low Clinic (only) for Oxygen Testing	Follow approved Protocol in Show Low Procedure Book.

Hand and Plastics Patients	<p>Patients who present to Hand & Plastics Clinic – scheduled or walk-in</p> <p>Requests may be entered ONLY by RN assigned for the day, in Hand & Plastics Clinic</p>	<p>X-rays MRIs EMGs Lab tests Prosthetic requests Fee Basis requests OT Consults</p>
Medication Requests	<p>New prescription or refill requests for the following medications:</p> <ul style="list-style-type: none"> a. Ace inhibitors b. Diuretics c. Lipid Lowering agents d. DM medications e. Thyroid Replacement medications f. Digoxin, Theophylline, Tegretol, and Dilantin 	<p>Order the following lab tests for Provider evaluation for prescription refills:</p> <ul style="list-style-type: none"> Chem. 7 LFT, Lipid panel Chem 14, HgbA1c TSH Drug levels for Digoxin, Theophylline, Tegretol, and Dilantin

5. **RESPONSIBILITY:**

- a. Associate Chief of Staff for Ambulatory Care is responsible for reviewing and approving this policy.
- ~~x~~b. The Ambulatory Care Nurse Managers are responsible for the implementation of this policy, including education, training and competency reviews.
- ~~x~~c. Ambulatory Care Registered Nurses are responsible for using the nursing process to implement clinical interventions as indicated.

6. **REFERENCE:** Telephone Triage Protocols for Nurses, Briggs 2002
Core Curriculum for Ambulatory Care Nursing, 2001
Merck Manual, 1992

7. **RECISSION:** Clinical Protocols for Professional Registered Nurses Ambulatory Care, Ambulatory Care Policy #10, May 1999.

**CARL T. HAYDEN
VA MEDICAL CENTER
PHOENIX, ARIZONA**

**AMBULATORY CARE POLICY NO. 46
MARCH 2006**

8. **EXPIRATION DATE:** March 2009

**M. KEITH PIATT, M.D.
Associate Chief of Staff
Ambulatory Care Service**

Exhibit G

Mitchell, Katherine L.

From: Mitchell, Katherine L.
Sent: Thursday, April 10, 2014 9:04 AM
To: Helman, Sharon M. (SES)
Cc: Burke, Christopher T.; Deering, Darren
Subject: Suicide Prevention Team & High Risk Vets

As a committee member on the RCA & the SEC, I remain deeply concerned regarding the lack of resources and support for the Suicide Prevention Team at the Phoenix VAMC. I am sending this letter directly to you because of the urgent nature of the situation and the service lines affected are outside my service line. My hope is that senior administration will direct resources to the SPT.

Both SPT case managers follow very high risk Veterans on a weekly basis – part of their duties for which they receive official credit. However, a significant part of their job duties are not officially credited and thus are often overlooked when assigning new tasks to them. Such duties include responding to Crisis Line calls/follow-up, outreach events, RPIW membership, SEC committee meetings, RCA committee meetings, training for various service lines, & new employee orientation duties. These activities can take 50% or more of their duty time.

There has never been any administrative support personnel assigned to the SPT so that the coordinator and case managers are frequently pulled away from direct patient care duties in order to fax, copy, mail, & do other clerical tasks that could be effectively done by an assistant.

Although a new case manager position was approved last Fall & noted in one of your Weekly Messages, the Phoenix VA has not yet posted that position during the last 5+ months so that active recruitment can begin.

David Klein, the former Suicide Prevention Coordinator, stepped down in February 2014. Unfortunately, his position has not yet been posted either in the last 2 months since he left. The individual who is assuming his duties is actually one of the two remaining case managers who is already swamped with his own case manager duties.

There currently are no psychiatrists on the SEC or RCA teams.

Although there has been some indication that recruitment will be from the internal cert list for the ED social worker posted position, at best that would only enable filling the empty case manager position (assuming such recruitment falls within federal recruitment guidelines/rules). The Suicide Prevention Coordinator position is a much higher grade level and would require a separate job posting.

Currently, the case managers on the Suicide Prevention Team are doing a fantastic job trying to juggle all their responsibilities in addition to providing excellent patient care to extremely challenging Veterans who are at highest risk for suicide. However, unless the Phoenix VA can provide immediate additional support, there is a high likelihood Veteran suicide deaths will continue to increase because the SPT is too diluted to do effective outreach & care to all our high risk Veterans who require such intensive case management.

Attempts by the involved committee members to obtain additional psych appt for high risk Veterans have not been successful on a routine basis because there are grossly inadequate mental health appt slots available.

OEF/OIF/OND Veterans tie with the Vietnam Vets for having the highest suicide rates at this facility. Within my own clinic, I have noted Veterans discharged from the hospital after severe depression/suicide attempts who have not been assigned a regular psychiatrist even after months. Other issues regarding the delayed scheduling of mental health appts

for the OEF/OIF/OND Veterans with severe PTSD/depression/anxiety have been significantly affecting the mental health care for those Veterans.

Although there is a mental health WIG occurring, recruitment is slow. It is important that our highest risk Vets get care, even if that care is fee-basis.

Sincerely,
Katherine Mitchell, M.D.