



DEPARTMENT OF VETERANS AFFAIRS
Washington DC 20420

September 10, 2015

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

RE: OSC File Nos. DI-15-0499 & DI-15-2813

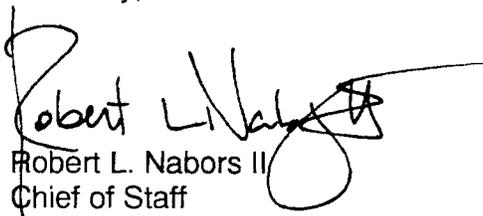
Dear Ms. Lerner:

I am responding to your letter regarding allegations made by whistleblowers at the White River Junction Department of Veterans Affairs (VA) Health Care System, (hereafter, the Medical Center) located in White River Junction, Vermont. Whistleblowers alleged that the Emergency Department was short staffed, mismanaged, not properly disinfected, and in violation of Veterans Health Administration pharmacy policies, resulting in a violation of law, VA directives, and a substantial and specific danger to public health. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary under 5 United States Code § 1213(d)(5).

The Interim Under Secretary for Health was assigned to review this matter and prepare a report in compliance with the § 1213(d)(5) requirements, and directed the Office of the Medical Inspector to assemble and lead a VA team to conduct an investigation. The report did not substantiate the first, second, and fourth allegations, but did substantiate shortcomings in disinfection efforts. The report makes seven recommendations to the Medical Center Director. We will send your office follow-up information describing actions that have been taken by the Medical Center Director and other entities to implement these recommendations.

Thank you for the opportunity to respond.

Sincerely,


Robert L. Nabors II
Chief of Staff

Enclosure

**DEPARTMENT OF VETERANS AFFAIRS
Washington, DC**

**Report to the
Office of Special Counsel
OSC File Numbers DI-15-0499 & DI-15-2813**

**White River Junction Veterans Affairs Medical Center
White River Junction, Vermont**



Report Date: June 25, 2015

TRIM 2015-D-357

Executive Summary

The Interim Under Secretary for Health (I/USH) requested that the Office of the Medical Inspector (OMI) assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the White River Junction VA Health Care System, (hereafter, the Medical Center) located in White River Junction, Vermont. The whistleblowers, who wish to remain anonymous, alleged that employees are engaging in conduct that may constitute violations of laws, rules or regulations, and gross mismanagement, which may lead to a substantial and specific danger to public health. VA conducted a site visit to the Medical Center on April 20–23, 2015.

Specific Allegations of the Whistleblowers

1. The ED [Emergency Department] is chronically short staffed, resulting in violations of Veterans Health Administration (VHA) directives;
2. The ^{RN 3} [REDACTED] has engaged in unsafe practices and provided medically inappropriate care when treating patients in the ED;
3. The ED is not properly disinfected in violation of Occupational Safety and Health Administration (OSHA) regulations, Centers for Disease Control (CDC) Guidelines and VHA Directives; and
4. The Medical Center lacks sufficient pharmacy coverage in violation of VHA policy, which results in Registered Nurses (RN) filling prescriptions in violation of their state nursing licenses.

VA **substantiated allegations** when the facts and findings supported that the alleged events or actions took place and **did not substantiate allegations** when the facts and findings showed the allegations were unfounded. VA was **not able to substantiate allegations** when the available evidence was not sufficient to support conclusions with reasonable certainty about whether the alleged event or action took place.

After careful review of findings, VA makes the following conclusions and recommendations.

Conclusions for Allegation 1

- VA **did not substantiate** that the ED is chronically short staffed, resulting in violations of VHA directives. While significant nursing staffing issues previously existed in the ED, the new ED Nurse Manager [REDACTED] submitted a request to the Resource Management Committee (RMC) in August 2014, to address these issues. During fiscal year (FY) 2015, ED RN roles were defined and separated from the Chief Nursing Officer (CNO) role, and staffing segmented to meet the minimum requirements in accordance with VHA Directive 2010-010, *Standards for Emergency*

Department and Urgent Care Clinic Staffing Needs in VHA Facilities, March 2, 2010. By February 2015, all ED vacancies had been filled. At the time of VA's investigation, the staffing issues had been resolved.

- VA **did not substantiate** the additional allegation that ED RNs are asked frequently to supervise multiple new nursing hires during their orientation to the Medical Center, creating the potential for patient care to be compromised. While schedules do substantiate one time when one RN worked with two orientees, the allegation that "they were asked frequently to supervise multiple employees" is not substantiated.
- The dedicated CNO positions are critical to the Medical Center's functions. Their support of the ED, if qualified to serve in that capacity, is valuable, especially during surges.
- VA determined that the ED Nurse Manager took prompt and appropriate action upon learning of the staffing deficiency. As a result, no accountability action is warranted.

Recommendations to the Medical Center:

1. Continue to explore salary and/or recruitment/retention options to recruit and retain qualified nursing personnel.
2. Continue to evaluate the volume and acuity of clinical cases to ensure appropriate staffing.

Conclusions for Allegation 2

- VA **did not substantiate** that the RN 3 [REDACTED] has engaged in unsafe practices and provided medically inappropriate care when treating patients in the ED. An OIG criminal investigation into the RN 3 [REDACTED] clinical care found the allegations to be unsubstantiated and revealed that these allegations were made based entirely on second-, third-, and fourth-hand information, and that those making the allegations were unaware of all the facts. As a result, no accountability action is warranted.
- VA concluded the clinical care and leadership oversight provided by the RN 3 [REDACTED] is clinically sound and vital to the Medical Center in providing care. The RN 3 [REDACTED] used her clinical skills to assist in providing clinical care when necessary. When a clinical care issue occurred, she filed an incident report regarding the Alaris pumps and worked with staff in the Medical Center to order the correct dosage needed for a particular medication during a medical emergency. As a result, no accountability action is warranted.

Recommendation to the Medical Center:

3. In accordance with the Medical Center's Peer Review Policy, MCM No. 00-14-93, complete peer reviews on the care of both Veterans identified in the October 2014 OIG investigation.

Conclusions for Allegation 3

- VA **substantiated** that the ED was improperly disinfected in violation of OSHA regulations, CDC Guidelines, and VHA Directives, which posed a danger to public health and safety.
- With the exception of one former ED employee, VA did not substantiate that any Veteran or ED staff member suffered from a rash or rash-like illness. The former employee, who told us that she had a rash, did not report it to Occupational Health. No ED staff member stated that they had directly observed insects, including mites, on ED curtains.
- VA found that at the time of the site visit, Environment Management Services (EMS) staff members were not thoroughly trained on standards in cleaning or fully aware of products stipulated for use by the *EMS Procedure Guide, 2012*; however, following the VA site visit, EMS leadership provided two educational training sessions for all EMS staff members.

Recommendations to the Medical Center

4. Ensure all EMS staff members are adequately trained according to the *EMS Procedure Guide* and establish a quarterly training program.
5. EMS leadership should report the status of hiring actions and the frequency of cleaning areas within the facility that are the subject of complaints or otherwise known to have EMS maintenance issues (i.e., floor care, changing of cubicle curtains, detail cleaning, etc.) to the Facilities Management Service and the Medical Center leadership team at least bimonthly.
6. EMS leadership, in conjunction with Human Resources (HR) and facility education staff, should develop written instructions for documenting the competencies of EMS employees and perform periodic random reviews of competency records.
7. Schedule a consultation visit from an external environmental program expert to identify and assess areas for improvement in the facility's problem-prone areas or areas with complaint histories like the ED. Following this visit, EMS leadership should develop an action plan to incorporate necessary change(s) and make additional improvements as indicated within a reasonable timeframe established by facility leadership.

Conclusions for Allegation 4

- **VA did not substantiate** that the Medical Center lacks sufficient pharmacy coverage in violation of VHA policy, which results in RNs filling prescriptions in violation of their state nursing licenses.
- VA determined that Medical Center leadership took prompt and appropriate action upon learning of the pharmacy coverage deficiency. As a result, no accountability action is warranted.

Recommendation to the Medical Center

None.

Summary Statement

OMI has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, the Office of General Counsel (OGC) has provided a legal review, and the Office of Accountability Review (OAR) has examined the issues from a HR perspective to establish accountability, when appropriate, for improper personnel practices. VA found violations of VA and VHA policy and found that improper disinfection in the ED also violated OSHA regulations and CDC Guidelines, posing a danger to public health and safety.

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I. Introduction

The I/USH requested that OMI assemble and lead a VA team to investigate allegations lodged with OSC concerning the Medical Center. The whistleblowers, who did not consent to the release of their names, alleged that the facility's ED is chronically short staffed, resulting in violations of VHA directives; the ^{RN 3} [REDACTED] has engaged in unsafe practices and provided medically inappropriate care when treating patients in the ED; the ED is not properly disinfected in violation of OSHA regulations, CDC Guidelines and VHA Directives; and the Medical Center lacks sufficient pharmacy coverage in violation of VHA policy, which results in RNs filling prescriptions in violation of their state nursing licenses. VA conducted a site visit to the Medical Center on April 21–23, 2015.

II. Facility Profile

The Medical Center is a complexity level 2 facility responsible for the delivery of health care services to eligible Veterans in a two-state service area, Vermont and New Hampshire.¹ These services are delivered at the Medical Center's main campus and at its seven outpatient clinics (Bennington, Brattleboro, Burlington, Newport, and Rutland, Vermont; Keene and Littleton, New Hampshire). The Medical Center is closely affiliated with the Geisel School of Medicine (formerly Dartmouth Medical School), the University of Vermont College of Medicine, and over 40 other nursing and allied health affiliations. The facility supports a research and residency training program.

The Medical Center provides a full range of primary, secondary, and specialty care, clinical services in its 74-bed, acute care facility, including 43 medical/surgical beds, 7 Intensive Care Unit (ICU) beds (medical and surgical), 10 psychiatry beds, and 14 Residential Recovery Center beds (a Substance Abuse Residential Rehabilitation Treatment Program). It maintained an average daily census of 52, a 70 percent occupancy rate, and had 263,369 outpatient visits during FY 2014.

III. Specific Allegations of the Whistleblowers

1. The ED is chronically short staffed, resulting in violations of Veterans Health Administration (VHA) directives;
2. The ^{RN 3} [REDACTED] has engaged in unsafe practices and provided medically inappropriate care when treating patients in the ED;
3. The ED is not properly disinfected in violation of OSHA regulations, CDC Guidelines and VHA Directives; and

¹ Complexity level 2: complexity levels are determined by patient population (volume and complexity of care), complexity of clinical services offered, and education and research (number of residents, affiliated teaching programs, and research dollars). Complexity level 1 is the most complex and level 3 are the least complex; complexity for level 2 facilities is considered moderate. (VHA *Executive Decision Memo* (EDM), 2011 Facility Complexity Level Model).

4. The Medical Center lacks sufficient pharmacy coverage in violation of VHA policy, which results in RNs filling prescriptions in violation of their state nursing licenses.

IV. Conduct of Investigation

The VA team conducting the investigation consisted of: [REDACTED] MD, Senior Medical Investigator (an Internist) and [REDACTED], FNP, Clinical Program Manager, both of OMI; [REDACTED] MD, (Emergency Physician), Emergency Medicine Field Advisory Committee; [REDACTED], ED Clinical Nurse Advisor, Office of Nursing Services (ONS); [REDACTED], Health System Specialist, ONS; [REDACTED], Environmental Service Program Office; [REDACTED], Registered Pharmacist, Associate Chief Consultant for Pharmacy Compliance and Efficiency, Pharmacy Benefits Management Services; and [REDACTED], HR Specialist. VA reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A. We held an entrance briefing with Medical Center and Veterans Integrated Service Network (VISN) leadership, conducted a tour of the ED, ICU, and pharmacy areas, and convened an exit briefing with Medical Center and VISN 1 leadership on the last day of the visit.

We also interviewed the following Medical Center employees on site:

- [REDACTED] RN, ED and ICU Nurse Manager
- [REDACTED] MD, ED Chief
- [REDACTED] RN, Clinical Nurse Educator
- [REDACTED] MD, ED Physician
- [REDACTED] RN, ED Nurse
- [REDACTED] EMS Supervisor
- [REDACTED] Chief HR
- [REDACTED] EMS, Day shift
- [REDACTED] Registered Pharmacist, (RPh), Chief, Pharmacy
- [REDACTED] RN, ED Nurse
- [REDACTED] RN, ED Nurse
- [REDACTED] EMS, Evening
- [REDACTED] RN, ED Nurse
- [REDACTED] Medical Center Director
- [REDACTED] RPh, Pharmacist Day
- [REDACTED] Medical Service Administrative Officer
- [REDACTED] ED, EMS Supervisor
- [REDACTED] RN, ED Nurse
- [REDACTED] RN, Chief, Infection Control Prevention
- [REDACTED] RN, Associate Director for Patient Care Services (ADPCS)
- [REDACTED] Chief of Staff
- [REDACTED] RN, Acting Risk Manager
- [REDACTED] RPh, Pharmacist Evening

- [REDACTED], RN, Chief Education, Acting Chief Quality Management
- [REDACTED], MD, ED Physician
- [REDACTED], Chief, Facility Management Service
- [REDACTED], RN, FNP, Associate Chief Nurse, Acute Care
- [REDACTED], MD, Associate Chief of Medicine
- [REDACTED], MD, ED Physician
- [REDACTED], RN, ED Nurse
- [REDACTED], RN, Patient Safety
- [REDACTED], MD, Chief, Anesthesia

VI. Findings, Conclusions, and Recommendations

Background

ED Triage

An ED does not function like an outpatient clinic. Patients are not scheduled for specific appointment times. At any moment of the day, patients can arrive with life-threatening conditions requiring treatment by any specialty. These conditions must be addressed promptly to avoid death and/or disability. An ED cannot reschedule patients for another day; there is no patient too ill for the department to treat within its capabilities and resources.

In EDs, triage officers, usually nurses, routinely assess, sort, and prioritize all patients who present for treatment. Triage systems are typically designed to identify the most urgent (or potentially most serious) cases to ensure that they receive priority treatment, followed by the less urgent cases on a first-come, first-served basis. Generally, resources are available to treat every patient, although, under standard medical practice, the less severely ill or injured must wait longer. Some patients may choose to leave the ED rather than continue waiting; to counter this, some EDs refer patients with very minor problems for treatment at clinics or to their own physicians.²

VHA Handbook 1101.05 *Emergency Medicine Handbook* states that RNs are to triage according to the Emergency Nurses Association (ENA) position statement on triage qualifications of July 1996; accordingly, the Medical Center's ED RNs perform triage according to the Emergency Severity Index (ESI), a standardized triage system that stratifies patients into five groups from 1 (most urgent) to 5 (least urgent), providing a method for categorizing ED patients by both acuity and resource needs.³ The ESI level 1 requires immediate interventions to save life, limb, or eyesight. Level 2, also high risk, is for the patient to whom you would give the last open bed: the patient may be confused, lethargic, disoriented, or in severe pain or distress. The level 3 patient requires two or more resources such as laboratory tests, x-rays, or intravenous (IV) fluids. If the level 3 patient's vital signs (e.g., blood pressure, respiratory rate, or heart

² Iverson, K.V. & Moskop, J.C., Triage in Medicine, Part I: Concept, History, and Types; *Annals of Emergency Medicine*; Volume 49, No. 3: March 2007, 275-281.

³ VHA Handbook 1101.05, *Emergency Medicine Handbook*, May 12, 2010.

rate) are outside the normal range, the triage nurse would consider upgrading the patient to level 2. A level 4 patient requires only one resource, such as an x-ray or laboratory test, and a level 5 patient may require only a prescription refill. From a clinical standpoint, ESI level 4 and 5 patients are stable and can wait several hours to be seen by a provider; mid-level practitioners such as physician assistants (PA) and nurse practitioners (NP) typically care for these patients in the ED setting.⁴

General nursing education does not adequately prepare RNs for the complexities of the ED triage nurse role. ENA recommends the completion of a standardized triage education course, which includes a didactic component and a clinical orientation with a preceptor, before being assigned triage duties. In addition, ED nurses are encouraged to acquire additional education to enhance triage knowledge and skills, including specific certification in emergency nursing, trauma, and geriatrics.

ED Patient Flow, Triage Processes and Volume

Upon her hiring in May 2014, the ED Nurse Manager noticed that triage was not occurring in accordance to the standard of practice and the VHA *Emergency Medicine Handbook*.

She noted:

- Patients arrived at the admissions desk, were registered, and sent to the ED waiting room not directly visible to the ED staff.
- If a patient appeared to be in distress, e.g., shortness of breath or chest pain, the administrative staff left their duty station to get an ED RN.
- The triage area was located in room 147, directly across from the behavioral health safe room and in the same room as the physician's office, separated only by a room divider.
- Following triage, patients were sent back to the waiting room if their condition was not emergent.

Both the American College of Emergency Physicians and the Joint Commission (TJC) recommend that emergency patients should be seen initially by a triage nurse and/or taken directly to an examination room if available, as patients may not know whether their symptoms represent an emergent or urgent condition. If, as a result of a triage evaluation, a staff member determines that the patient is in need of emergency care, a physician must examine the patient promptly and furnish that care. The ED Nurse Manager has made changes in the triage process to ensure that an RN assesses patients upon arrival.

⁴ Emergency Severity Index (ESI), *A Triage Tool for Emergency Department Care*, Version 4, Implementation Handbook, 2012 Edition. Agency for Healthcare Research and Quality. <http://www.ahrq.gov/professionals/systems/hospitals>

In her previous place of employment (non-VA), the ED Nurse Manager used bedside triage whenever possible. Through discussion and practice, she demonstrated how this practical approach to triage would make sense at the Medical Center. She obtained ESI training materials and assigned this training in the Talent Management System (TMS) to all ED RNs. She had nursing protocols and reference manuals created to assist and educate nursing staff with assessment, documentation, and nursing interventions, and reviews charts weekly to assess ESI levels, providing education as needed.

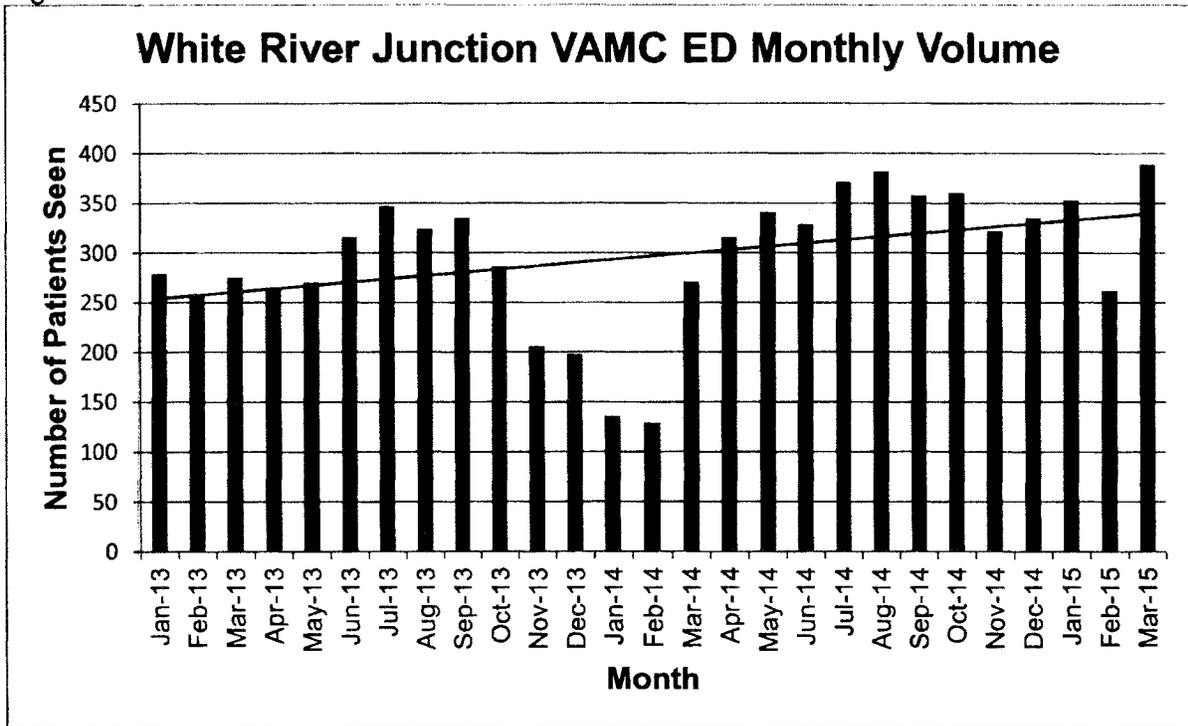
The ED currently has an eight-chair waiting room down a hall and around the corner from its entrance. This is entirely out of view from the triage area currently located in the anteroom of a closed ambulance garage. The lack of camera surveillance of the waiting area is concerning, given the lack of direct visibility. The ED Nurse Manager assumed responsibility for moving triage to an area adjacent to the ED for direct visibility and plans further renovations to improve patient flow and visibility of the waiting room in the near future (Attachment B).

The department consists of a total of five beds, of which four are located in one large room and separated by dividing curtains on ceiling tracks. All of the beds have bedside monitoring; however, their proximity and curtain separation does little to enable privacy. A fifth room down a hall is used as a "quiet room" for behavioral health patients or as a negative airflow room for infectious disease patients as need arises. Both in the past and present, there are times when the nurse may be away from the ED for patient transport or busy with patient care and unable to perform triage. In the past there was only one RN on duty to perform all these tasks. VHA Directive 2010-010, page B-2, mandates the availability of sufficient staff to ensure that the ED has continuous coverage.

Veterans presenting to the ED are initially seen by the Administrative Officer of the Day (AOD), a clerical worker who documents their presenting illness and notifies a nurse to admit the patient, but patients may not enter the locked ED triage area directly. VHA Handbook 1101.05 requires that the ED be designed to provide a safe environment for patients and staff while making access convenient and protecting visual and auditory privacy to the extent possible. The ED Nurse Manager changed the triage process by moving the triage location to an area adjacent to the check-in desk to ensure that nursing personnel are able to assess patients upon arrival. While the Medical Center has at least one RN in the ED at all times, this nurse may be alone without immediately available backup, particularly during evening and night shifts.

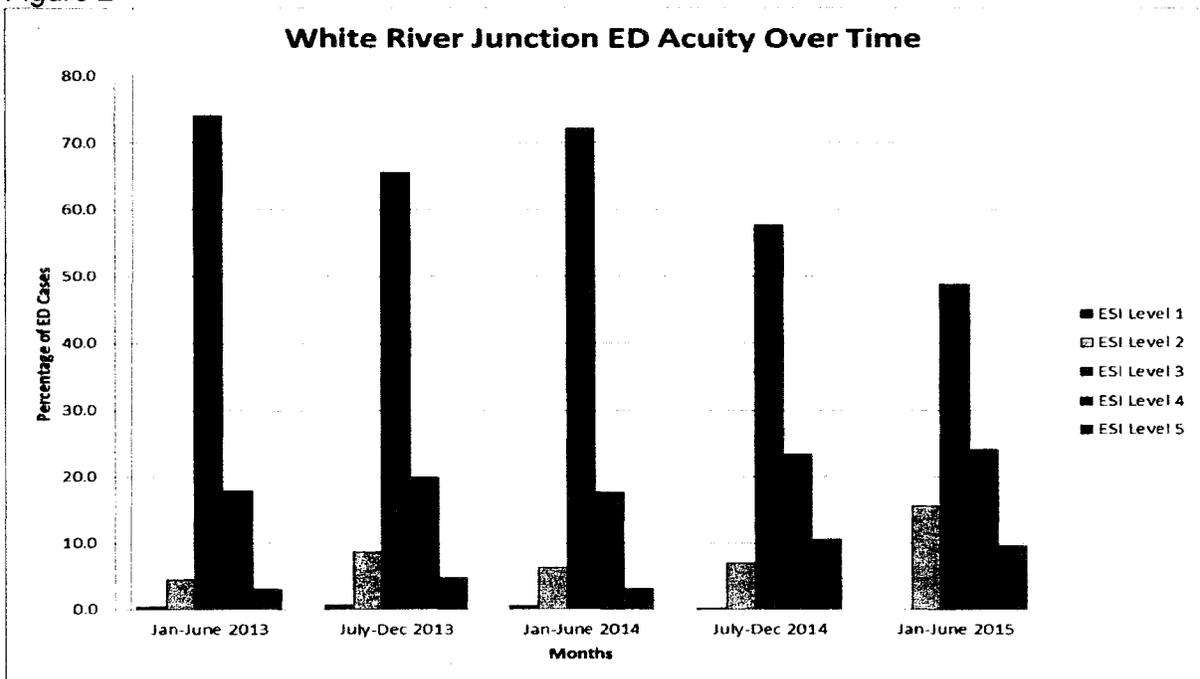
The ED's volume is variable with a monthly standard deviation of approximately 10 percent or more when compared to past FYs. In FY 2014, the department saw 3,323 patients, according to Emergency Medicine Management Tool (EMMT) data (Figure 1).

Figure 1



The trend over the past two FYs is an increase in overall ED visits, while the severity of ESI levels has changed. The number of ESI level 1, 3 and 5 cases has decreased, and ESI level 2 and 4 cases have increased. (Figure 2)

Figure 2



VHA Directive 1051, *Standards for Nomenclature and Operations in VHA Facility Emergency Departments*, mandates that physician staff members work “acceptable shift lengths of 8-, 10-, or 12-hour shifts.”⁵ An occasional 16-hour shift may be scheduled...” but this must be closely monitored. A review of the physician schedule found a shift length of up to 16 hours in January 2015, 20 hours in February and 25 hours in March. VA discussed with leadership our concerns regarding the lengths of these shifts and the quality of the providers. These appeared to be post-graduate medical staff with 3 years of training in internal medicine currently on staff at the local academic affiliate. Many of these physicians are engaged in sub-specialty internal medicine training and do not have focused training in emergency medicine.

One interviewee suggested that shift length, particularly on weekends and holidays, was routinely 24 hours in length. We confirmed this by a review of the published schedules of ED physicians and that of the Medical Officer of the Day (MOD). Although physician leaders maintained new recruitment plans for their own ED staff physicians are underway, a review of the USA Jobs Web site on April 26, 2015, found a total of 16 positions posted for the entire facility: none of them were for emergency physicians, and the only one for the ED/ICU was for an RN.

The ED has a number of challenges as surge capacity is limited due to the number of beds available based on the physical plant and the current staffing level. Several interviewees from both the clinical and administrative staff commented on the planned ED renovations. These include provisions to add a room for behavioral health emergencies and to reconfigure the isolation room to accommodate gynecological examinations, but they do not address the privacy issues associated with the four curtained rooms. They do; however, create a separate triage area from a portion of the AOD office. A tentative plan to further expand the ED would remove a non-weight-bearing wall to allow the creation of several separate examination rooms. The proposed ED renovation plans utilize VHA document, *Space Planning Criteria for Emergency Department/Urgent Care Clinic Revision*, of October 10, 2012.

Allegation 1

The ED is chronically short staffed, resulting in violations of Veterans Health Administration (VHA) directives.

In the letter from OSC, the whistleblowers provided six examples of patient care episodes that demonstrated occasions in which various patients required immediate and one-on-one care from an RN. To investigate these examples, VA requested the identifiers of these Veterans; however, we were informed “the whistleblowers do not have the patient identifiers” and that “the date ranges in the referral letter should be helpful in determining which cases should be evaluated.” As a result, VA reviewed ED patient logs on the referenced dates, July 7 and July 15, 2014, to identify and review

⁵ Although not specifically mentioned in the OSC letter, VA reviewed physician staffing during the site visit.

medical records of the Veterans most likely described in the letter for each clinical scenario.

Findings

The summary of encounters for the 24-hour period beginning at 7:00 a.m. on July 7, 2014, includes a total of 16 patients who presented to the ED. There was an average of six patients in the ED throughout each hour of the day.

- Eight patients were admitted to the Medical Center from the ED; three went to the inpatient telemetry unit and five went to the medical/surgical ward.
- Seven patients were discharged home.
- One patient was sent to the outpatient clinic for nonemergent problems and was not seen in the ED.

The whistleblowers described a subsequent incident that occurred in the second week of July 2014, when four patients presented to the ED within a 30-minute period.

The summary of encounters for the 24-hour period beginning at 7:00 a.m. on July 15, 2014, includes a total of 20 patients who presented to the ED. There was an average of six patients in the ED throughout each hour of the day.

- Seven patients were admitted to the Medical Center from the ED; one went to the inpatient telemetry unit and six went to the medical/surgical ward.
- Ten patients were discharged home.
- Two patients were sent to the outpatient clinic for non-emergent problems and were not seen in the ED.
- One patient's name was entered in error.

The VA team reviewed the electronic health records (EHR) for all Veterans seen on this day and noted that on the referenced dates that multiple patients were seen within a small time span with serious presenting complaints. Their complaints warranted extensive and close involvement by both the ED physician and nurse. The medical care provided was appropriate; however, it is noted that multiple sick patients presenting to the ED in a short time span, as occurred on each of these days, could easily put a strain on clinical resources, most notably the nursing staff.

VHA Nurse Staffing in the ED

According to the OSC letter, the whistleblowers alleged that the ED is staffed by one nurse per shift, explaining that one nurse is not capable of triaging, treating, and observing multiple patients at the same time, or addressing issues outside of the ED in fulfillment of the dual CNO role, both frequent situations. VHA Directive 2010-010 states: "EDs must have adequate staff and resources available to evaluate all individuals presenting to the ED." The Directive further notes that: "Evaluation, management, and treatment of patients must be appropriate and expedient." The

whistleblowers asserted that staffing the Medical Center's ED with one nurse per shift seriously compromised the ability of the department to provide appropriate care.

That Directive and the VHA Handbook 1101.05 provide the minimal staffing requirements for the ED. The Handbook states: "Appropriately educated and qualified emergency care professionals staff the ED during all hours of operation. This includes, at a minimum, a registered nurse and a licensed physician credentialed and privileged to work in the ED. ED volume, complexity, and flow rate are important information needed to determine the number of staff members required. A plan established and supported by the medical center must exist for additional nursing, provider, and support staff in times of acute overload or disaster."⁶

The Directive states "the emergency or urgent care physician, emergency or urgent care nurse, and additional medical team members are the core components of the emergency or urgent care medical system. Effective working relationships need to be established with other health care providers and entities with whom they must interact. Timely emergency care by an ED physician and ED nursing staff, physically present in the ED, must be continuously available 24 hours a day, 7 days a week (24/7)."⁷

In accordance with the Handbook and the Directive, the minimal staffing requirement for EDs is one RN present at all times. Staffing levels fall below the one RN minimum requirement if additional assignments outside the standard scope of work for an ED RN, decrease the available work load capacity below one dedicated ED nurse. Additionally, one ED RN must be continuously available to ED patients, so assignments that pull the sole qualified ED nurse from the department is considered a violation of both the Handbook and the Directive.

VHA Nurse Staffing Methodology in the ED

The calculation to determine full time equivalent employees (FTEE) to adequately staff the ED with one RN at all times is:

$$\text{FTEE} = [(365)(24)(\text{number of RNs})(\text{Leave Factor})] / 2080$$

The number of RNs refers to the number of RNs scheduled at any given time throughout the day.

Using the minimum leave factor for all inpatient units of 1.2, per VHA Directive 2010-034, the minimum calculated FTEEs required to staff one RN in the ED at all times is 5.05 FTEE.⁸ If 1.2 does not adequately reflect reality, and the actual occurrence of variables affecting leave is greater, then the ED will be in violation of VHA Handbook 1101.05 and VHA Directive 2010-010. If ED RNs are expected to leave the ED, then

⁶ VHA Handbook 1101.05, *Emergency Medicine Handbook*, May 12, 2010.

⁷ VHA Directive 2010-010, *Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities*, March 2, 2010.

⁸ VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.

one RN is not sufficient to comply with the Handbook and the Directive. At least two ED RNs should be scheduled if they must leave the department for various reasons. In this case 10.10 ED nurse FTEEs are required at a minimum. Calculated staffing levels for the ED, which vary depending on the length of shifts worked, are provided in Tables 1 and 2.

Table 1

8 Hour Shift Minimum to Provide Projected ED and CNO Schedule					
Shift	Hours/Day	Days/Week	Hours/Week	FTEE	FTEE with 1.2 Leave Factor
1 RN at All Times	24	7	168	4.2	5.04
1 RN Split Shift	8	7	56	1.4	1.68
1 CNO Weekends	24	2	48	1.2	1.44
1 CNO Weekday Nights	8	5	40	1	1.2
1 CNO Weekday Evenings	12	5	40	1	1.2
Totals					10.56

Table 2

12 Hour Shift Minimum to Provide Projected ED and CNO Schedule					
Shift	Hours/Day	Days/Week	Hours/Week	FTEE	FTEE with 1.2 Leave Factor
1 RN at All Times	24	7	168	4.2	5.04
1 RN Split Shift	12	7	84	2.1	2.52
1 CNO Weekends	24	2	48	1.2	1.44
1 CNO Weekday Nights	12	5	60	1.5	1.8
1 CNO Weekday Evenings	12	5	60	1.5	1.8
Totals					12.6

An analysis of the approved schedule is demonstrated in the charts above. In order to provide one ED RN at all times, one extra ED RN for the split shift between day and night, and one CNO, the required FTEEs range from 10.56 to 12.6.

The June 2012 ED Organizational Chart showed seven ED RN positions and one ED Nurse Manager position, a total of eight FTEEs. In August 2012, the ED implemented three CNO positions to be filled by RNs, with a request for three additional FTEEs. The CNO responsibilities include:

- Acting as a clinical care expert and consultant (reviewing quality of care, performing rounds, conducting case reviews, etc.)
- Initiating/implementing performance improvement activities

- Performing Quality Improvement audits
- Sharing expertise and educating nurses
- Coordinating patient care at the facility level

The Medical Center’s justification for these CNO positions was included in its RMC request of August 1, 2012, that stated: “According to VHA Directive 2010-010, [the Medical Center] can no longer allow the ED RN to also be assigned responsibility for organization-wide activities. This Directive mandates the RN be present in the ED at all times, with the sole responsibility to treat [ED] patients.” This meant that the CNO role had to be completed by another RN at the Medical Center.

An RMC Request of January 6, 2014, shows that the Medical Center was unable to fill any of the CNO positions, and still had problems with hiring nursing staff for the ED RN positions as well. The Request also indicated that ED nurses were unable to perform the CNO role effectively when they were needed for ED patient care, so it included a proposal to relocate the CNO positions to the ED, and add 1 FTEE. This Request verified that the CNO “routinely leaves the ED to make rounds, assist with patient care issues, and retrieve medications from the pharmacy.” It stated that, with approval, the ED would have two RNs scheduled at all times. One nurse would be scheduled as the ED RN, and the other scheduled as the CNO (who would also serve as the ED RN backup) to ensure a nurse is present in the ED at all times. The approved proposal increased the FTEEs to nine ED RNs and three CNOs, providing one ED RN at all times, one extra ED RN for the split shift between day and night, and one CNO position during the week from 3:00 p.m. until 7:00 a.m., and all day on weekends and holidays. Table 3 shows the authorized and actual ED RN FTEEs. The ED Nurse Manager is actively recruiting to fill the remaining RN vacancy; in the meantime, the current RN and CNO staff members are covering all shifts.

Table 3

<i>Fiscal Year</i>	CNOs		RNs (includes the Nurse Manager)	
	Authorized	Actual	Authorized	Actual
2012	3	0	8	7.5
2013	3	0	8	6
2014	3	1	9	6
2015	3	3	9	8

ED RN Schedules

Interviews confirmed that prior to [REDACTED] being hired as the ED Nurse Manager in May 2014, ED nurses had been scheduled as the only ED RN, as well as the CNO. VA’s review of March and April 2014, ED nurse staffing schedules showed that ED RNs assumed the CNO role during weekend, holiday, evening, and night (WHEN) hours.

Even though the schedule does not reflect CNO scheduling, most nights RNs acted as the only RN in the ED and as the facility CNO, with or without an orientee as well. Interviewees report that the CNO role occupied 30-50 percent of an ED RN's scheduled time. When nurses worked alone in the ED, with CNO responsibilities, the nurse only spent 50-70 percent of the time dedicated to the department. Nurses reported having to leave patients alone in the ED to perform CNO-related tasks.

During this investigation, VA reviewed the 2012 to 2014 Organizational Charts, RMC Requests, and RMC Minutes that showed that prior to the ED Nurse Manager's arrival, the ED had been in violation of mandatory minimal staffing requirements as defined in VHA Handbook 1101.05 and VHA Directive 2010-010. VA's review of the early FY 2014 ED RN staffing schedules confirms that the ED often scheduled one RN or CNO per shift, which caused the department to be chronically short staffed. In response to these issues, the ED Nurse Manager immediately implemented plans to alleviate these scheduling constraints by:

- Implementing an immediate plan to hire new ED RNs
- Authorizing the use of overtime to cover shifts
- Authorizing the use of other facility RNs, including ICU nurses, Nurse Managers, and the Patient Safety Officer to cover shifts
- Using the Traveling Nurse Corps (TNC)

In June 2014, a consultant for TJC expressed concerns about nurse staffing in the ED not following the staffing methodology per the VHA Directive. The Medical Center Director met with the Patient Safety Officer, Chief Quality Officer, and Nursing Leadership and charged Nursing with implementing immediate corrective actions to ensure safe staffing levels and coverage in the ED (Attachment C).⁹

When asked about challenges related to RN recruitment, nursing leadership said that they identified salary discrepancies with other large medical facilities in the area. The Medical Center recently received approval to modify ED nursing salaries in accordance with the local market, and its leadership has been evaluating additional options to recruit and retain qualified nursing personnel.

The ED Nurse Manager has successfully recruited six RNs to fill vacancies. Additionally, in consultation with Medical Center leadership and HR, she worked to transfer two RNs who she felt were not progressing in ED clinical skills and training, to other units within the Medical Center. By the end of FY 2014, the ED schedule no longer had single RNs covering shifts. Its current staff has an average of 14 years clinical experience as RNs, with the longest being 37 years and shortest 2.5 years, and all have ED experience. As confirmed through interviews, the ED RN staffing meets the staffing methodology criteria, and the CNO continues to provide support to the ED nursing staff as needed.

⁹ Time line from Medical Center Director provided April 23, 2015.

Additional Allegation

During the site visit, one interviewee expressed an additional allegation that ED RNs are asked frequently to supervise multiple new nursing hires during their orientation to the Medical Center, creating the potential for patient care compromise. One of the ED nurses stated that she was regularly assigned three newly hired RNs who were undergoing orientation while she also worked as the sole ED RN and CNO. She reported that this happened during her shift on several occasions.

When asked for additional details, this RN described the orientees as a TNC RN with ED experience; a medical-surgical unit RN with 2 years' experience; and an RN with 1 year of experience. While all three were new to the department and two lacked ED experience, all had prior nursing experience.

VA's review of the March and April 2014 ED nurse staffing schedules confirm that ED RNs were scheduled with an orientee at night; in addition this RN served as the CNO. VA's review of the staffing schedules from May 2014 to March 2015, confirms the ED RN and CNO roles and duties are separate; however, on one night in July 2014 and two nights in August 2014, there was only one RN serving in both the ED RN and CNO roles.

According to the three most recent ED RN hires, all explained that their orientation consisted of working with an assigned preceptor. The July 2014, ED RN schedule shows the three newly hired orientees working a day shift, but each was assigned to an individual preceptor. One of the assigned preceptors called out sick for that shift, so one RN assumed preceptor duties for two of the nurses. According to one of the nurses in orientation, the RN on duty seemed "upset" that both of them were there. That nurse further stated that the RN on duty (whom they had not yet met) may have thought in error that they were brand new RNs without any nursing experience or that they would both have to work under her RN license. One ED RN whom we interviewed stated that she had served as a preceptor but could not recall ever having more than one orientee at a time. Other than this one noted exception, the rest of the nursing staff told VA that they each had been assigned only one new orientee at a time.

Both the previous Assistant ED Nurse Manager and current ED Nurse Manager indicated that their practice was to pair one RN with one orientee. However, there does not appear to have been a formal unit orientation program or plan in place prior to the arrival of the current ED Nurse Manager. Of note, the current orientation plan allows for needed flexibility in the requirements by permitting individual plans to be tailored to account for the individual orientee's work history, clinical experience, and clinical progression. The plan was developed in collaboration with the assigned preceptors, the ED Nurse Manager, and Nursing Education.

Conclusions for Allegation 1

- VA **did not substantiate** that the ED is chronically short staffed, resulting in violations of VHA directives. While significant nursing staffing issues previously existed in the ED, the new ED Nurse Manager, [REDACTED] submitted a request to the RMC in August 2014 to address these issues. During FY 2015, ED RN roles were defined and separated from the CNO role, and staffing segmented to meet the minimum requirements in accordance with VHA Directive 2010-010, *Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities*, March 2, 2010. By February 2015, all ED vacancies had been filled. At the time of VA's investigation, the staffing issues had been resolved.
- VA **did not substantiate** the additional allegation that ED RNs are asked frequently to supervise multiple new nursing hires during their orientation to the Medical Center, creating the potential for patient care to be compromised. While schedules do substantiate one time when one RN worked with two orientees, the allegation that "they were asked frequently to supervise multiple employees" is not substantiated.
- The dedicated CNO positions are critical to the Medical Center's functions. Their support of the ED is valuable, especially during surges.
- VA determined that the ED Nurse Manager took prompt and appropriate action upon learning of the staffing deficiency. As a result, no accountability action is warranted.

Recommendations to the Medical Center:

1. Continue to explore salary and/or recruitment/retention options to recruit and retain qualified nursing personnel.
2. Continue to evaluate the volume and acuity of clinical cases to ensure appropriate staffing.

Allegation 2

The ^{RN 3} [REDACTED] has engaged in unsafe practices and provided medically inappropriate care when treating patients in the ED.

In response to complaints, the Office of the Inspector General (OIG) conducted a criminal investigation in FY 2014 of actions taken by the ^{RN 3} [REDACTED]. The results of that investigation are summarized here.

Previous OIG Investigation

The OIG case was based on allegations from confidential sources that negligence may have contributed to the death of a patient, and that the ^{RN 3} [REDACTED] may have attempted to cover up her actions by entering false information into the VA

RN 3 falsified the vital signs of a patient and that she took nearly 20 minutes to administer Dopamine.¹⁰ Regarding the vital signs, the sources suggested that the RN 3 had fabricated blood pressure readings, because those readings had not been entered into CPRS until several hours after the Veteran's presentation to the ED and were inconsistent with the Veteran's condition. Regarding the delay, the sources claimed that she had been unable to get the Alaris pump to function properly, and thereby contributed to the patient's death.¹¹

In its report of November 13, 2014, the OIG found the allegations to be unsubstantiated and based entirely on second-, third-, and fourth-hand information. Further, the complainants were unaware of the crucial fact that the incidents cited were unrelated, as they pertained to **two** elderly Veterans, not one. According to OIG's synopsis, "VA doctors advised the delay did not contribute to the patient's death, and RN 3 is the individual who filed an Incident Report about the programming issues with the Alaris pump to VA management" (Attachment D).

The OIG briefed VA management on the programming issue involving the Alaris pumps: those at the Medical Center were programmed to administer ratios of Dopamine/Saline Solution that the Medical Center's Pharmacy did not carry. This caused a systemic delay in the administration of the drug while nursing staff did the math to ensure the correct amount of drug was delivered to the patient.

The OIG found no evidence of a "cover up" or an attempt to fabricate records. Because the investigation found no criminal activity, this report is considered administrative in nature and is closed (see synopsis of the OIG report, Attachment E). The OIG did not complete a clinical review of either Veteran's Care. As a result, we completed a clinical review of the Veterans identified in the report, reviewing the records of both of the Veterans. Our review found no evidence in either record that would support the allegations that the clinical care provided by the RN 3 was deficient. We asked whether incident reports and peer reviews on the cases of the two Veterans were available, but the facility was unable to provide them. According to the Medical Center's Peer Review Policy, Medical Center Memorandum (MCM) No. 00-14-93 dated March 12, 2014, a peer review is to be conducted following cardiac arrests. VA also asked the Patient Safety Manager whether any Root Cause Analyses (RCA) had been conducted pertaining to care provided in the ED since calendar year 2014; we were informed that "there were no RCAs related to the ED in calendar year 2014 or 2015."¹²

When asked about the RN 3 clinical skills, several providers were emphatic about her raising the bar for nursing practice. One physician said that she "has elevated the standards of nursing care within the ED." Several clinicians stated

¹⁰ Dopamine is a drug used to treat shock and hypotension.

¹¹ Alaris is the brand name of a commercially available IV medication infusion pump. These pumps can be programmed by clinicians to administer specific doses of medication over a specific period of time.

¹² Root cause analysis is a collective term that describes a wide range of approaches, tools, and techniques used to uncover causes of problems. A root cause is a factor that caused a nonconformance and should be permanently eliminated through process improvement. American Society for Quality© <http://asq.org/learn-about-quality/root-cause-analysis/overview/overview.html>

she could be direct and to the point when it came to clinical care, and that she would point out things that would benefit the patient. Nursing leadership stated that she has turned the ED around and made it a better functioning unit, and the ED nurses trust her judgement and clinical decision making. One physician, who requested to be interviewed by VA, stated that since the RN 3 [REDACTED] has been at the Medical Center, she has made some very positive changes in the Department. The physician also stated that she trusts the RN 3 [REDACTED] in providing clinical care. Other clinicians said that the RN 3 [REDACTED] could be abrupt in communication at times; however, she is 110 percent engaged and committed to nursing care. They feel the ED runs well under her leadership. Previously, they had gone through six [REDACTED] in the past 6 years. One physician also stated that the RN 3 [REDACTED] did a great job in [REDACTED]

Conclusion for Allegation 2

- VA did not substantiate that the RN 3 [REDACTED] has engaged in unsafe practices and provided medically inappropriate care when treating patients in the ED. An OIG criminal investigation into the RN 3 [REDACTED] clinical care found the allegations to be unsubstantiated and revealed that these allegations were made based entirely on second-, third-, and fourth-hand information, and that those making the allegations were unaware of all the facts. As a result, no accountability action is warranted.
- VA concluded the clinical care and leadership oversight provided by the RN 3 [REDACTED] is clinically sound and vital to the Medical Center in providing care. The RN 3 [REDACTED] used her clinical skills to assist in providing clinical care when necessary. When a clinical care issue occurred, she filed an incident report regarding the Alaris pumps and worked with staff in the Medical Center to order the correct dosage needed for a particular medication during a medical emergency. As a result, no accountability action is warranted.

Recommendation to the Medical Center:

3. In accordance with the Medical Center's Peer Review Policy, MCM No. 00-14-93, complete peer reviews on the care of both Veterans identified in the October 2014 OIG investigation.¹³

Allegation 3

The ED is not properly disinfected in violation of Occupational Safety and Health Administration (OSHA) regulations, Centers for Disease Control (CDC) Guidelines and VHA Directives.

¹³ Peer reviews for quality management are protected under 38 U.S.C. 5705

EMS is the sole service responsible for the cleanliness of the Medical Center. According to VHA Directive 1805, the Chief, EMS is responsible to the Medical Center Director for the operation of EMS, adapting the program to fit special circumstances, and advising and assisting management on all matters pertaining to health care environmental program functions and operations. EMS uses *EMS Procedure Guide, 2012* to assist in creating Standard Operating Procedures; to follow Infection Control, OSHA, and TJC standards; and develop criteria for training and competency checklists to ensure a safe and clean environment.

Findings

Our investigation revealed that EMS workers do not receive adequate training. In VA's review of the competency folders of the ED housekeeping staff, it was not clear who trained the employees we interviewed (Attachment F). We noted that the EMS competencies were all signed in one day. Although there is no standard timeframe to train employees on their competencies, we question whether employees could be trained in one day, given the amount of items and complexities associated with the EMS employee training. We also noted there is not a complete signature block from either the employee or supervisor who had instructed the training. The competency assessment form (Attachment F) was not signed by the supervisor or employee. This gives the impression that this document and perhaps others were not used for the intended purpose of assessing employee competencies, since there is no indication that the content was communicated or discussed with the employee.

When VA interviewed two of the housekeeping staff assigned to the ED, both said that they were trained by another EMS employee, not their supervisor. While these employees were knowledgeable about the cleaning process, when asked about some housekeeping chemicals, they could not state their intended purposes. One employee said that during his orientation, he shadowed three people for one week. He said that one in particular was very detailed when it came to cleaning, but that EMS training is not universal. When asked whether the EMS Supervisor was involved in his training, he replied, "No." When asked about one of the new cleaning products (Steriplex) used throughout VA facilities, he said that "he didn't know too much about it and that he wasn't one of the people who received training."¹⁴ Another member of the EMS staff indicated that floor care in the ED had not been done since July 2014, and he did not know when the floor finish would be applied to protect the floors.

VA's investigation also revealed evidence of a lack of cleanliness in the ED. In several interviews nurses said that they only see housekeeping staff once or twice during their shifts. Nurses said they routinely terminally clean beds themselves, especially at night when there is no housekeeping staff on duty.¹⁵ Several of the nurses, including the ED

¹⁴ Steriplex SD is for used to disinfect hard, non-porous surfaces in Healthcare and other areas where control of cross contamination is required and meets OSHA Bloodborne Pathogen Standards. It cleans, disinfects, & deodorizes in one step without bleach. It eliminates more than 99.999% bacteria and germs in 30 seconds and it kills *Clostridium difficile* spores, bacteria, viruses, & fungi in 5 minutes. <http://www.steriplex.com/steriplex-sd-proven-efficacy.html>

¹⁵ Terminal cleaning is describes a cleaning method used in healthcare environments to control the spread of infections. Terminal cleaning methods vary, but usually include removing all detachable objects in the room, cleaning

Nurse Manager, said they swept and mopped floors and dusted in the ED as needed. VA observed that walls were not clean, door facings were dirty, and the tops of cabinets needed dusting. A review of the Medical Center's projects for cleaning and waxing (June 2014–March 2015) found no indication that the ED floor had been cleaned and waxed during this time (Attachment G). According to the Environmental Programs Service (EPS) cleaning schedule, "floors are vacuumed or dust- and wet-mopped daily" (Attachment H).

VA also reviewed email communication between the ED Nurse Manager and the Chief, EPS, regarding the lack of cleaning and the lack of housekeeping coverage in the ED. Despite these findings during our site visit in April 2015, one month earlier a TJC surveyor found no areas of concern regarding cleanliness in the ED during a focused survey of the Medical Center, and during the same month as VA's on-site investigation, the Medical Center successfully completed its triennial survey with no recommendations or deficiencies for environment of care pertaining to Infection Control standards or cleanliness in the ED.

During VA's investigation, we asked EMS Leadership whether the ED could be deep cleaned on the night shift (11:00 p.m.–7:00 a.m.) since the ED has much less traffic at this time. They replied that they did not have any staff working the night shift and had not scheduled anyone to maintain the area overnight; they also alluded to the fact that they are short staffed: they currently have six vacant positions and have had problems keeping positions filled. A senior nurse leader also said, "We struggle with cleanliness. We go through housekeepers like a hot knife through butter. They do the best they can with what they have. Sometimes this does not always meet the expectations of nursing staff."

Housekeeping Aide positions have historically had a high turnover rate at the Medical Center, and low staffing levels appear to be a root cause of ongoing dissatisfaction with the delivery of EMS functions in the ED: cleaning and sanitation there have been adversely impacted. EMS leadership has taken steps toward stabilizing the EMS staffing for the ED, and ED clinical staff members corroborate these changes.

According to the OSC letter, "the whistleblowers further explained that on a daily basis ED staff observed insects, including mites, on hospital curtains. The whistleblowers asserted that in the fall of 2014, multiple ED employees contracted rashes, which were also observed on ED patients, and were attributed to a lack of terminal and routine cleaning of the ED."¹⁶

VA reviewed the EHRs of 36 Veterans who had been seen in the ED during the July 2014 time period, and did not find any evidence of rashes or rash-like illnesses among these patients. Medical Center staff could not provide us with any information on patients who had rashes or rash-like illnesses during the fall of 2014. VA spoke with the

lighting and air duct surfaces in the ceiling, and cleaning everything downward to the floor. Items removed from the room are disinfected or sanitized before being returned to the room.

¹⁶ OSC Letter to the Secretary VA, March 19, 2015.

Medical Center Director, CoS, ADPCS, Assistant Chief Nurse of Acute Care, and many others regarding any reports of rashes on staff members. With one exception, no staff member could confirm that anyone from the ED suffered from rashes or rash-like illnesses during that time. The one staff member who told us she had a rash, did not report it to Occupational Health. An Occupational Health memorandum states there were no reported cases of rashes by any staff member of the ED in FY 2014. VA did find that on June 6, 2014, a work order had been placed for pest control; however, the room to be treated was located in the ICU and the pest control technician found no evidence of infestation (Attachment I).

The updated and current status of corrective actions taken by EMS, with respect to cleaning processes in the ED, follows:

1. EMS' annual deep cleaning schedule is in compliance with VHA EPS guidebook; however, as a result of the VA site visit, to immediately address concerns raised, EMS accelerated this annual floor maintenance and completed deep cleaning of the ED on April 27, 2015.
2. Effective June 28, 2015, EMS created a third shift to improve coverage and cleanliness throughout the critical patient care areas of the Medical Center, including the ED, in order to provide 24-hour housekeeping coverage 7 days a week. The third shift coverage allows for increased routine floor care during the hours when the ED patient census is lowest.
3. The floor cleaning process at the Medical Center follows the manufacturer's recommendation to apply four layers of wax annually, and then to "wet square scrub" the floors 4 times a year as maintenance.
5. All curtains in the ED were exchanged in June 6, 2015 and July 22, 2015. Prior to this review, the curtains were exchanged on December 9, 2014 and March 6, 2015. Curtains will continue to be exchanged on a quarterly basis and/or as needed if there is evidence of soiling.
5. EMS staff clean all ED stretchers completely every week, per the current SOP. With the addition of the third shift, supervisors have found that these stretchers are actually receiving a complete cleaning on a daily basis. Current SOPs are being evaluated; EMS is in consultation with the Infection Control Practitioner to determine if they should be changed.
6. EMS leadership completed ED-specific training for all housekeeping staff on May 11, 2015 and June 24, 2015.

Conclusions for Allegation 3

- VA **substantiated** that the ED was improperly disinfected in violation of OSHA regulations, CDC Guidelines, and VHA Directives, which posed a danger to public health and safety.
- With the exception of one former ED employee, VA did not substantiate that any Veteran or ED staff member suffered from a rash or rash-like illness. The former employee, who told us that she had a rash, did not report it to Occupational Health. No ED staff member stated that they had directly observed insects, including mites, on ED curtains.
- VA found that at the time of the site visit, EMS staff members were not thoroughly trained on standards in cleaning or fully aware of products stipulated for use by the *EMS Procedure Guide, 2012*; however, following the VA site visit, EMS leadership provided two educational training sessions for all EMS staff members.

Recommendations to the Medical Center

4. Ensure all EMS staff members are adequately trained according to the *EMS Procedure Guide* and establish a quarterly training program.
5. EMS leadership should report the status of hiring actions and the frequency of cleaning areas within the facility that are the subject of complaints or otherwise known to have EMS maintenance issues (i.e., floor care, changing of cubicle curtains, detail cleaning, etc.) to the Facilities Management Service and the Medical Center leadership team at least bimonthly.
6. EMS leadership, in conjunction with HR and facility education staff, should develop written instructions for documenting the competencies of EMS employees and perform periodic random reviews of competency records.
7. Schedule a consultation visit from an external environmental program expert to identify and assess areas for improvement in the facility's problem-prone areas or areas with complaint histories like the ED. Following this visit, EMS leadership should develop an action plan to incorporate necessary change(s) and make additional improvements as indicated within a reasonable timeframe established by facility leadership.

Allegation 4

The Medical Center lacks sufficient pharmacy coverage in violation of VHA policy, which results in Registered Nurses (RN) filling prescriptions in violation of their state nursing licenses.

Pharmacy Hours and Staffing

The Medical Center Director became aware in 2013 that nursing was performing some pharmacy functions after regular pharmacy hours, prompting her to initiate discussions with pharmacy and nursing to identify solutions. The Director approved additional pharmacy staff to extend hours of operation from 7:30 a.m. – 6:00 p.m. on weekdays to 7:30 a.m. – 11:30 p.m., 7 days per week. A contract solicitation for virtual pharmacy services to cover the period from 11:30 p.m. to 7:30 a.m. was announced on November 26, 2013, and awarded on December 31, 2013. The contractor was allowed time to hire staff, and actual implementation of the virtual pharmacist and consequent 24-hour coverage began on May 25, 2014.

With the virtual pharmacy in place, pharmacy took additional steps to expand on-site hours of operation to 7:30 a.m. to 11:30 p.m. - or 16 hours per day, 7 days per week – effective November 8, 2014. The virtual pharmacist verifies all medication orders prescribed electronically when the on-site pharmacy is closed. Because the virtual pharmacist is not physically on site after 11:30 p.m., the CNO may need to retrieve medication(s) from the inpatient pharmacy, as described in the following section.

The Medical Center Director said that TJC discussed pharmacy staffing during the closeout of the Triennial Survey in June 2014, and indicated that coverage as it is currently organized is fine. TJC also recommended having pharmacists assigned to specific inpatient units and increasing the role of clinical pharmacists on the inpatient units.

RN Duties Regarding Medication Administration

The whistleblowers allege the Medical Center lacks pharmacy coverage during off-hours, and as a result, RNs routinely fill prescription orders. The whistleblowers allege that RNs process orders through the computerized pharmacy prescription system and ignore any system-generated warnings so medication can be approved and dispensed from automated systems.

VA's investigation found no evidence that RNs violated either state nursing practice statutes or VHA policies. Generally, state nursing laws allow nurses to administer drugs to patients based on a licensed independent practitioner's (LIP) order, but not to fill prescriptions. The actions of the RN staff members do not constitute filling prescriptions for medications, which involves preparing, packaging, labeling, documenting, and transferring the medication to the patient, as well as verifying that the prescription is indicated to treat the medical ailment, appropriate and safe.

TJC standards for Medication Management, MM.05.01.01, address the review of medication orders by a pharmacist. Specifically, standard MM.05.01.01 requires a pharmacist to review all medication orders or prescriptions before dispensing or removing medications from floor stock or from an automated storage and distribution device, such as a Pyxis MedStation® (Pyxis), **unless** a LIP controls the ordering, preparation, and administration of the medication, or when a delay would harm the patient in an urgent situation (e.g., sudden changes in a patient's clinical condition), in accordance with law and regulation (Attachment K).¹⁷

Per TJC, when medications are administered under an LIP, a retrospective pharmacy review is not required. When an on-site pharmacy is not open 24 hours a day, 7 days a week, a health care professional determined to be qualified by the hospital, such as a pharmacy technician, reviews the medication order in the pharmacist's absence. In these cases, a pharmacist conducts a retrospective review of all medication orders during this period as soon as a pharmacist is available or the pharmacy opens. For ED patients at the Medical Center, a pharmacist verifies orders within 24 hours of administration. For hospitalized patients, an on-site pharmacist or virtual pharmacist verifies all non-urgent medication orders prior to administration by a nurse. To comply with these standards, the Medical Center promulgated Medical Center Memorandum (MCM) Number 119-14-06, *Use of VA Prescription Forms, Medication Order Forms, and Electronic Medication Orders*. Paragraph 4.f. (4) states that during off tour hours, prescription orders may be administered by RNs from the Pyxis located in the emergency room.

Section 11.9, *Designated Nurse Access*, allows for one supervisory RN in any given 8-hour shift to be responsible for administering drugs obtained from the main Pyxis located in the inpatient pharmacy. The Medical Center's CNOs are authorized to access the medications in the Pyxis during the WHEN hours. In order to administer medications safely, and in accordance with VHA Handbook 1108.06, *Inpatient Pharmacy Services*, 13.a., "when the on-site pharmacy is not open 24 hours a day and 7 days a week, a licensed independent practitioner must review the medication order in the pharmacist's absence."¹⁸ When a pharmacist is not available, a licensed independent practitioner reviews prescriptions so that a CNO, or other staff RN, may access the Pyxis to administer medications to patients. The nurses interviewed said they obtain medications from the Pyxis for immediate administration to patients, or they obtain pre-packaged medication to give to the ED physician to dispense to the patient at the time of discharge. TJC permits EDs to broadly apply exceptions to the requirement for a pharmacist review when the medications are ordered by a LIP and administered by

¹⁷ Pyxis is an automated medication dispensing system that supports medication management with various features for safety and efficiency. The system helps accurately dispense medication, giving nurses fast and easy access to the medications including after hours. The Medical Center utilizes several Pyxis stations within its pharmacy system, which is staffed by pharmacy technicians. The medications are prepackaged drugs in amounts sufficient for immediate therapeutic requirements used in the ED and for inpatient use. <http://www.carefusion.com/medical-products/medication-management/medication-technologies/pyxis-medstation-system.aspx>

¹⁸ A licensed independent practitioner is defined as any practitioner permitted by law and by the organization to provide care and services, without direction or supervision, within the scope of the practitioner license and consistent with individually assigned clinical responsibilities. <http://www.apna.org/files/public/LIPClarification.pdf>

staff permitted to do so, such as RNs. A second exception allows medications to be administered in urgent situations when a delay in doing so would harm the patient.

In using the Pyxis, only an authorized nurse can access the system using an access code and/or password/biometrics. As nurses administer medications from the Pyxis system, they verify that all information regarding the order is correct. In following the rules of patient safety, the nurse is responsible for ensuring that the right patient is receiving the right medication.¹⁹ All medication orders are reviewed for the following:

- a. Patient allergies or potential sensitivities.
- b. Existing or potential interactions between the medication ordered and food and medications the patient is currently taking.
- c. The appropriateness of the medication, dose, frequency, and route of administration.
- d. Current or potential impact as indicated by laboratory values.
- e. Therapeutic duplication.
- f. Other contraindications.

After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing.

MCM 119-14-06 further states in paragraph 4.f.(5), "In the event of documented need to provide patients with medication during Pharmacy's off tour hours, a staff pharmacist may be contacted for return to duty in accordance with standing policy." In the event that the LIP determines the need for pharmacist involvement, the AOD is authorized to call in an off-duty pharmacist and maintains a copy of the call back roster (Attachment J). During interviews, we noted that most of the pharmacists live within 10-20 minutes of the Medical Center in accordance with the Medical Center's expectations regarding on-call availability.

Conclusions for Allegation 4

- VA **did not substantiate** that the Medical Center lacks sufficient pharmacy coverage in violation of VHA policy, which results in RNs filling prescriptions in violation of their state nursing licenses.
- VA determined that Medical Center leadership took prompt and appropriate action upon learning of the pharmacy coverage deficiency. As a result, no accountability action is warranted.

Recommendation to the Medical Center

None.

¹⁹ Eight rights of medication administration, Lippincott Nursing Center @ <http://www.nursingcenter.com/>

Summary Statement

OMI has developed this report in consultation with other VHA and VA offices to address OSC's concerns that the Medical Center may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, or created a substantial and specific danger to public health and safety. In particular, the OGC has provided a legal review, and OAR has examined the issues from a HR perspective to establish accountability, when appropriate, for improper personnel practices. VA found violations of VA and VHA policy and found that improper disinfection in the ED also violated OSHA regulations and CDC Guidelines, posing a danger to public health and safety.

Attachment A

Documents in addition to the Electronic Medical Records reviewed.

Centers for Medicare and Medicaid Services, S&C: 13-20-Acute Care Guidance for Hospitals, Critical Access Hospitals (CAHs) and Ambulatory Surgical Centers (ASC) Related to Various Rules Reducing Provider/Supplier Burden.

Contract No. V797D-30128 with Medical Staffing Network Healthcare, LLC.

Emergency Department Staff Schedule, March 2–8, 2014.

Emergency Department Staff Schedule, March 9–15, 2014.

Emergency Department Staff Schedule, March 16–22, 2014.

Emergency Department Staff Schedule, March 23–29, 2014.

Emergency Department Staff Schedule, March 30–April 5, 2014.

Emergency Department Staff Schedule, April 6–12, 2014.

Emergency Department Staff Schedule, April 13–19, 2014.

Emergency Department Staff Schedule, April 20–26, 2014.

Emergency Department Staff Schedule, April 27–May 3, 2014.

Emergency Department Staff Schedule, January 25–February 7, 2015.

Emergency Department Staff Schedule, February 8–21, 2015.

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Organizational Chart–Associate Director for Nursing/Patient Care Services VAMC 405, April 26, 2013.

Organizational Chart–Associate Director for Nursing/Patient Care Services VAMC 405, August 26, 2013.

Organizational Chart–Associate Director for Nursing/Patient Care Services VAMC 405, April 4, 2014.

Organizational Chart–Associate Director for Nursing/Patient Care Services VAMC 405, July 23, 2014.

Organizational Chart–Associate Director for Nursing/Patient Care Services VAMC 405, February 27, 2015.

Organizational Chart–Associate Director for Nursing/Patient Care Services VAMC 405, April 24, 2015.

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Organizational Charts for the Medical Center’s Pharmacy Department.

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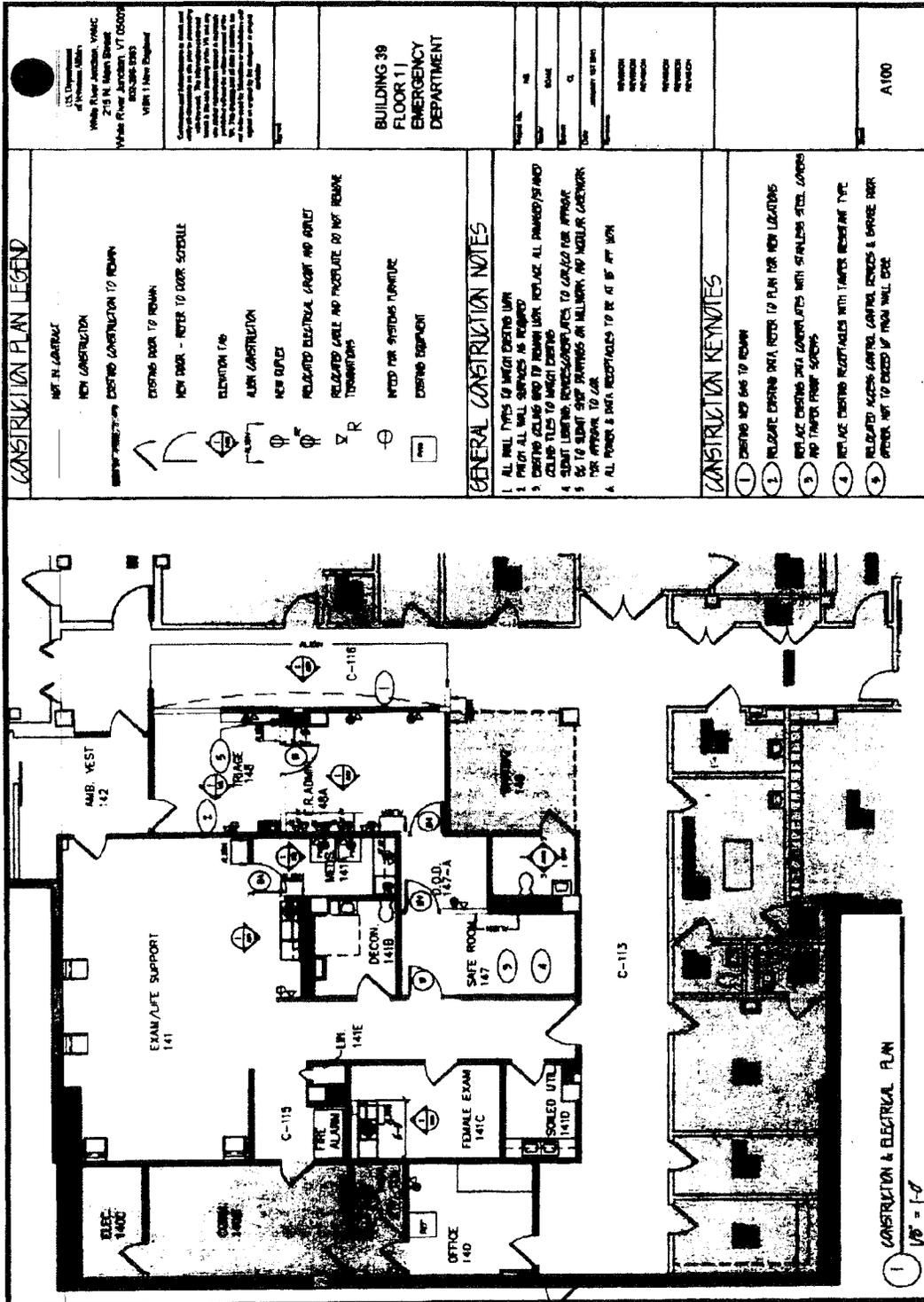
White River Junction VAMC Resource Management Committee Meeting Minutes,
March 13, 2014.

White River Junction VAMC Resource Management Committee Meeting Minutes,
January 23, 2014.

White River Junction VAMC Resource Management Committee Meeting Minutes,
June 12, 2014.

White River Junction VAMC Resource Management Committee Meeting Minutes,
June 26, 2014.

Attachment B ED Design



**Attachment C
Medical Center Director's Timeline**

June 12, 2014:	<i>TJC Consultant Visits the Medical Center and expresses significant concern about nurse staffing in the ED.</i>
	Met with Nursing Leadership, Patient Safety Officer, Chief Quality Officer to review staffing and charged nursing with putting immediate fixes into place to ensure safe staffing levels/coverage in the ED.
Actions taken:	<i>Authorized overtime or whatever else needed to make this happen.</i>
	<p>Staffing managed with:</p> <ul style="list-style-type: none"> • Overtime for ED • Nurse Managers Taking Shifts • Patient Safety Officer Taking Shifts • Nurse Detailed from ICU • Nurse Travelers <p><i>Shortly after JC Consultant was at the facility, Leadership Team reviewed VHA Directive 2010-010 Standards for Emergency Department and Urgent Care Clinic – Staffing Needs in VHA Facilities: Leadership Team agreed it should be mandatory to have 2 nurses in ED during high volume times (noon to 8 pm) and separate nursing supervisor role from ED coverage. Nursing Supervisor available as support to ED during WHEN hours. Nursing completed risk assessment, met with staff, consulted with ED Medical Director/Chief of Medicine as well. Based on volume and acuity they did not feel that we met high complexity/high volume criteria at that time. Staffing has since been increased to 2 RNs (7:30 am until midnight) as acuity/volume increasing.</i></p> <p><i>Approved additional nurse travelers for ED</i></p> <p><i>Approved additional permanent staff for ED</i></p>
June 26, 2014	<i>Approved 6 CNA/LNA positions for ED (in risk assessment became clear that nurses were performing tasks that could be handled by others).</i>
	<ul style="list-style-type: none"> • <i>Made rounds in ED off tours/checked staffing levels (I continue to do this)</i> • <i>Asked ADPAS [redacted] to meet directly with staff in ED to discuss staffing plans and hear concerns of ED staff</i> • <i>Weekly meetings with ADPAS [redacted] on-going – used as an</i>

	<i>opportunity to review this issue on an on-going basis.</i>
Week of August 10, 2014	<i>Met with ED Nurse RN 1 who expressed concerns about ED staffing, in particular having several orientees to supervise at one time. She also expressed concerns about Manager 1 management style. Thanked her for bringing the concerns forward. Discussed concerns with ADPAS requesting she look into the issue of staff being asked to mentor several orientees in ED and review staffing levels again.</i>
August 13, 2014	<i>Contacted NCOD, spoke with Executive Director and explained concerns regarding potentially punitive culture in Nursing Service, particularly the ED.</i>
August 14, 2014	<i>E-mail received from RN 1 stating that she felt intimidated by nursing leadership for having come to see me. Also expressed concerns about RN 2 who she felt was being targeted and 'set up to fail'. Shared this e-mail with NCOD.</i>
	<p><i>Met with ADPAS and Manager 1 to discuss concerns. Discussed supervision of orientees and how this process worked. Commitment made by nursing to ensure alternate supervision in place, only one orientee per experienced nurse in ED at any time. Also discussed concerns regarding Manager 1 management style. She acknowledged frustration regarding staff resistance to change and needed improvements in ED processes. Emphasized that expectation was that behavior of any supervisor was supportive of their staff and need for commitment to foster a culture of psychological safety.</i></p> <p><i>ADPAS committed to coaching Manager 1 on a regular basis. ADPAS stated she felt that Manager 1 was a skilled clinician and she could work with her to improve management style. Manager 1 acknowledged concerns and need to provide more support to staff and institute change more slowly.</i></p> <p><i>Subsequent to this I also met with Manager 1 on several occasions and discussed leadership style and how to approach certain situations.</i></p> <p><i>HR/Nursing/AFGE/Employees involved in identifying appropriate placement for both RN 1 and RN 2</i></p>
August 15, 2015	<i>Spoke with NCOD to request assistance in addressing perceived punitive culture in nursing service. Shared information regarding</i>

	<p>above situation and previous perceptions. They shared that it would be October/November before they could make a site visit. They did agree to initiate interviews with other Quadrad members in the interim. Either the 15th or the 16th met with ADPAS and discussed engagement of NCOD. ADPAS requested that I consider engaging ONS in a review process first. Agreed to do this. Connection made with ONS on August 17th to arrange for site visit by a team of seasoned Nurse Executives with focus to be on nurse staffing, processes and culture.</p>
September 9, 2014	<p>received from RN 2 by HR via email. She had received a</p> <p>Met with RN 2 and agreed to discuss options with nursing/HR.</p> <p>Due to background in suggested to Manager 2 (Nurse Manager in RN 2 that she evaluate whether RN 2 might be a good fit for Manager 2 agreed that she would potentially be a good fit. ADPAS did express concerns regarding RN 2 Manager 2 agreed to work with Nursing Education and this employee to ensure competence for role as RN on inpatient unit.</p> <p>In retrospect, should have had this connection handled by Nursing Service as they are responsible for nurse competencies. ONS shared this with me at their closeout and I agree.</p>
September 10, 2014	<p>Notification that RN 2 would be joining</p>
September 29-October 2, 2014	<p>ONS Consultants on Site: In close-out with me they indicated that morale in nursing service overall was good. They did not feel there was a punitive atmosphere. Made some suggestions regarding giving nurses more input into scheduling for better work-life balance. Indicated they had spent time with ADPAS discussing leadership/culture/etc.</p>
Week of October 27, 2014	<p>Notified by OIG Criminal Investigator they were doing an investigation based on information received from confidential sources alleging that the negligent actions of RN 3 may have contributed to the death of a patient and attempts were then made to cover this up by entering false information into the record. Issues also raised regarding difficulties programming an Alaris pump to administer pressors to this patient.</p> <p>Was aware of issues related to pump from Morning Meeting the day after this incident occurred (October 21, 2014). Discussed the</p>

	<p><i>concern about the pump and charged Associate Director to immediately engage Bio-Medical Engineering and Pharmacy to rectify. QM held some meetings related to this – engaged the VISN to address and resolve.</i></p> <p><i>The OIG Criminal Investigator met with me (I believe the end of the week) and shared that there was no evidence of a cover-up or attempt to fabricate record. They found that no crime had occurred. He also indicated that OIG was aware that the facility was already addressing the concerns regarding programming of the Alaris pump.</i></p>
<p>Additional Information for Consideration:</p>	<ul style="list-style-type: none"> • <i>Pharmacy staffing and coverage has been discussed in multiple venues over past 6 months. Additional positions have been approved for Pharmacy. Contract in place for virtual Pharmacist during WHEN hours. TJC discussed pharmacy staffing during closeout of Triennial Survey and indicated that coverage as it is currently organized is fine. They did recommend having pharmacists assigned to specific inpatient units and increasing the role of clinical pharmacists on the inpatient units. Have asked Chief Pharmacy Service to re-assess having in person coverage when additional staff on board and current contract for virtual Pharmacist ends.</i> • <i>March 4-5, 2015: TJC Focused Survey (included ED): no requirements for improvement identified in the survey.</i> • <i>April 7-10, 2015: TJC Triennial Survey: (included ED): only RFI related to ED was the location of the Code Cart.</i>

Attachment D Alaris Pump Incident Report

Incident related to: [REDACTED] Event ID: 301

Subject Type: Inpatient Event Date: [REDACTED]

Event Type: Med Error - Adverse Event Time (24:60): 12:30 Sex: [REDACTED]

Injury: Death Sentinel Event: [REDACTED] Age At Event: [REDACTED] DOB: [REDACTED]

Event Main Location: WRJ MC - Inside Building

Event Sub Location: Ward

Ward/Clinic/Other: ICU

Room: [REDACTED]

Summary Incident Reports White River Junction VAMC

	Event Date	ID	Injury	Incident Narrative
Med Error - Adverse Event	[REDACTED]	301	Death	ICU Delay in administering Dopamine via pump during a code as the concentration of the premixed drug is not programmed in to the pump. RN had to do long hand math and drip calc and verify with another RN delaying drug in a code with a BP of 70 After asking ICU staff about this they said they have raised this concern over a year ago and it never got fixed. This pt expired
Inpatient	[REDACTED]			Prevention Narrative Process developed for pump programming to be done prior to any change in drug calculation

Attachment E Report Synopsis

This case was initiated based on information received from confidential sources alleging that the negligent actions of a RN 3 [REDACTED] at the Medical Center, may have contributed to the death of a patient, and that the RN 3 [REDACTED] may have attempted to cover up her actions by entering false information into the VA medical notes. Specifically, the sources (1) questioned whether the RN 3 [REDACTED] ever took the vital signs of a patient and suggested she fabricated blood pressure readings, because the blood pressure readings were not entered into the medical record until several hours later and those entered in the record were inconsistent with the veteran's condition; and (2) alleged that the RN 3 [REDACTED] took nearly 20 minutes to administer Dopamine because she could not get the Alaris pump to function properly, thereby contributing to the patient's death.

Investigation found the allegations to be unsubstantiated. Investigation revealed that these allegations were made based entirely on second, third, and fourth-hand information, and that those making the allegations were unaware of all the facts – to include that the incidents raised were unrelated and actually involved the deaths of two elderly veterans, not one. Regarding the alleged Dopamine incident that occurred on [REDACTED] with an [REDACTED]-year old veteran, the investigation confirmed that there was a 10-20 minute delay in administering Dopamine due to a known issue with the Alaris pump, epinephrine was administered in the interim per doctor's order. VA doctors advised the delay did not contribute to the patient's death, and the RN 3 [REDACTED] is the individual who filed an Incident Report about the programming issues with the Alaris pump to VA management. Regarding the alleged failure to take vital signs and fabrication of VA medical records belonging to an [REDACTED] year old veteran on [REDACTED] [REDACTED] investigation disclosed that the RN 3 [REDACTED] and another nurse did immediately take the Veteran's vital signs upon arrival at the VAMC and were assisted soon after by VA physicians, though they were unable to save the veteran who died of heart failure. Investigation found no evidence of a "cover up" or an attempt to fabricate records.

VA OIG briefed VA management on the programming issue involving the Alaris pump. Specifically, the Alaris pump(s) at the Medical Center was programmed to administer ratios of Dopamine/Saline Solution which the Pharmacy did not carry, causing a systemic delay in the administration of the drug while nursing staff did the math calculations so the desired amount of drug was delivered to the patient. VAMC management said they were working on resolving this issue.

Because investigation found no crime occurred, this report is considered administrative in nature.

This case is closed.

**Attachment F
Employee Competencies**

Housekeeping New Employees Orientation Checklist

Employee Name	PPE	Chemical Usage	Linen Procedures	D.O.T. Red Bags	Radiation Monitor	Different Codes	Shred Program	Doors Leading Outside to Trash Compactor	Precaution Room Cards	Precaution Rooms	6 & 7 Step Cleaning	Cart and Housekeeping Closets
[REDACTED]	11/25/14	11/25/14	11/25/14	11/25/14	11/25/14	11/25/14	11/25/14	11/25/14	11/25/14	11/25/14	11/25/14	11/25/14

WHITE RIVER JUNCTION, VERMONT

CENTER MEMORANDUM 05-11-40
ATTACHMENT B

June 15, 2011
(002ED)

CORE COMPETENCIES OF HPDM

Name of Employee: [REDACTED] Date: 11/20/2014
 Position/Grade: [REDACTED] Department: EPS
 Assessment: Initial (on entering department) _____ Annual Review _____ Period: 10/1/14 to 9/30/15
FY15

CORE COMPETENCIES of the HIGH PERFORMANCE DEVELOPMENT MODEL (Section A & B below and Section C or D on page 2 must be completed on every employee)		Verification Method	Competency Code	Completion Date
A. MANDATORY TRAININGS (APPLY TO ALL POSITIONS) (FY 14) ** Competencies are set annually by WRJ Leadership Team				
1.	Compliance Business Integrity (CBI)	M	S	8/5/14 (NEG)
2.	VA Privacy and Information Security Awareness	M	S	8/5/14 (NEG)
3.	Emergency Response Management	M	S	8/5/14 (NEG)
4.	Environment of Care	M	S	8/5/14 (NEG)
5.	Annual Government Ethics	M	S	8/5/14 (NEG)
6.	Fire Extinguisher Training Information Security (biannual)	M	S	8/5/14 (NEG)
7.	Fire Prevention and Safety/Life Safety	M	S	8/6/14 (NEG)
8.	GEMS Awareness Training	M	S	8/5/14 (NEG)
9.	General Workplace Safety	M	S	8/5/14 (NEG)
10.	No Fear/Sexual Harassment (every 2 years)	M	S	8/6/14 (NEG)
11.	Overcoming Stigma toward Veterans with Mental Illness	M	S	8/6/14 (NEG)
12.	Military Cultural Awareness (for non Veterans)	M	S	8/6/14 (NEG)
B. CORE COMPETENCIES				
1.	Technical Skills (Technical skills for this position are listed on page 2)	V	SNS	9/30/14 - 1/5
<i>The remaining core competencies (items 2-8) are developmental competencies and employees will be in varying stages of development on each. Please enter the level number (1,2,3 or 4) from attachment 2 which best describes the employee's level and then enter the competency code and verification method.</i>				
2.	Personal Mastery	Level: 2 3 4	DR	S N 11/20/14 11/1/15
3.	Interpersonal Effectiveness	Level: 2 3 4	DR	S 11/20/14
4.	Customer Service	Level: 2 3 4	DR	S 11/20/14
5.	Flexibility/Adaptability:	Level: 2 3 4	DR	S 11/20/14
6.	Creative Thinking:	Level: 2 3 4	DR	S 11/20/14
7.	Systems Thinking:	Level: 2 3 4	DR	S 11/20/14
8.	Organizational Stewardship	Level: 2 3 4	DR	S 11/20/14

VERIFICATION METHOD	COMPETENCY CODE
OB- Observation D- Demonstration V- Verbalization T-Test/Quiz DR-Document Review M-Mandatory Review Completion O- Other (specify)	S- Satisfactorily Meets N- Needs Review and Practice
	Supervisor Signature: [REDACTED]
	Employee Signature: _____
	Date Discussed with employee: _____

Name of Employee: _____ Date: 11/30/14
 Position/Grade: HOUSEKEEPING A10 Department: EPS
 Assessment: Initial (on entering department) _____ Annual Review _____ Period: 10/1/14 - 9/30/15
FY 15

HPDM- CORE COMPETENCIES GRID

POSITION SPECIFIC TECHNICAL SKILLS (COMPETENCIES)	Verification Method	Competency Code	Completion Date
C. Position Specific Competencies: This section should be completed for all positions.			
Understanding of Proper PPE usage within a discharge/precaution room cleaning.	V/DR	S	8/6/14
Understanding of 5+7 cleaning procedures	V/DR	S,N,S	8/6/14 - 10/27 - 1/14/15
Understanding of chemical usage...	V/DR	S	10/6/14
Understanding of and proficient in the employee leave responsibilities. VISTA	M	S	9/1/14
Understanding of ALL RME items outside of the OR.	V/DR	S	11/15/14
CDC Cleaning requirements discharge room cleaning precaution level 2	V/DR	S	11/15/14
**Understanding and proficient in SPD cleaning procedures.	V/DR	S	1/16/15
**Understanding and Proficient in the 797 SOP pharmacies.	V/DR	S	1/16/15
**Understanding of ALL RME items within the OR	V/DR	S	1/15/14 (2 DAYS)
** UNDERSTANDING OF ALL RME ITEMS IN THE ED	V/DR	S,N	1/16/15 1/1/15
** SPECIFIC STAFF REQUIRED.			

VERIFICATION METHOD	COMPETENCY BODY
OB- Observation D- Demonstration V- Verbalization T-Test/Quiz DR-Document Review M-Mandatory Review Completion O- Other (specify)	<p style="text-align: center;">S- Satisfactorily Meets N- Needs Review and Practice</p> <hr/> Supervisor Signature: _____ Employee Signature: _____ Date Discussed with employee: _____

Orientation/Training 30 day Schedule		
Employee:	Start Date: 1/17/15	Date complete
Day		
	Receive assigned locker, keys, uniforms, See Dorothy Ward for data info and over view of vista, Introduction to employees, facility tour.	1/28/15
	Linen room procedures, folding, sorting, stock levels and explanation of various kinds of linen, pick up and delivery of laundry to floors.	1/28/15
	Trash and linen pick up through out the facility, Scrub-ex location and usage, do stairwells, corridors and afternoon linen run. Proper PPE usage, hand hygien.	1/28/15
	Dally routine reavew and locations.	1/28/15
	Proper use of chemicals, PPE usage, cleaning and manatenance.	1/28/15
	Trash and linen pick-up/delivery. RMW handing locations and DOT handing, using PPE.	1/28/15
	Equipment reavew, usage cleaning and Manitenance.	
	Bathroom cleaning, JCHAO and common bathroom, sign off sheets.	1/28/15
	Cart set up, cleaning, mantenance, and proper storage.	1/28/15
	Precaution room cleaning, PPE uauge and explanation of different types.	1/28/15
	Outer building routine and process.	
	Begin assigned TOUR 1st/2nd. Reitroduction to staff, Shadow work LDR	1/28/15
	Facility tour, question and answer etc.	1/28/15
	1st shift work with staff 1 South.	1/28/15
	2nd Shift work with staff building 39 Green Mountion Firm.	
	1st Shift work with staff 1-West.	1/28/15
	2nd Shift work with staff in building 39 White Mountion Firm.	
	1st Shift work with Ground East (Housekeeper)	
	2nd Shiftwork staff in SDS and PAC-U, Building 31.	
	1st Shift work with staff in ICU, PAC-U and ER building 31/39.	1/28/15
	2nd Shiftwork with staff in SPD, Desk 80, PT/OT building 31	
	1st Shift work with staff in building 28	
	2nd Shift work with staff in Canteen and desk 100.	
	1st Shift work with staff in Core area 1-W/1-S.	1/28/15
	2nd Shift work with staff in building 1.	
	1st Shift work with staff in building 31 floor care.	1/28/15
	2nd Shift work with staff in building 44.	
	1st Shift work in linen room and corridors, scrub-ex reavew.	1/28/15
	2nd Shift work linen in corridors, scrub-ex reavew.	
	1st Shift all area reavew with work leaders, Question and Concerns.	1/28/15
	2nd Shift all area reavew with work leaders, Question and Concerns.	
	If not interested in training in OR start working with other employee in assigned areas.	

Attachment G

WAXING PROJECTS

DATE	BUILDING# ROOM# PROJECT	NAME OF	# OF STAFF ON PROJECT	# OF HOURS SPENT ON PROJECT
6/10/2014	Bldg 44	Room 2-117A		8
6/25/2014	Bldg 31,	ICU		8
6/26/2014	Bldg 31	ICU		8
6/30/2014	Bldg 31	ICU Room 3 & hallways		8
7/1/2014	Bldg 31,	ICU strip and Wax		40
7/1/2014	Bldg 31	ICU Room 1 and Hallway		8
7/2/2014	Bldg 31	ICU Room 4		8
7/14/2014	Bldg 6 and	Bldg 7		8
7/31/2014	Bldg 4			8
8/11/2014	MRI			8
9/3/2014	Canteen and	VCS Store		8
9/3/2014	Bldg 1	Room 157		8
9/5/2014	Bldg T-4			8
9/5/2014	Bldg T-62			8
9/9/2014	Bldg 28	Room 217		3
9/10/2014	Bldg T-61			8
9/10/2014	Bldg 28	Room 218		3
9/16/2014	Bldg 28	Room 216		3
9/24/2014	Bldg 9			8
9/29/2014	Bldg 31	Pacu hallway		8
10/10/2014	Bldg 31	GI hallway		8
10/13/2014	Bldg 31	OR Hallways		8
10/16/2014	Bldg 31	OR Hall in front of elevators		4
10/19/2014	Bldg 1 and	Bldg B hallway to WMF		8
10/20/2014	Bldg T-44	main room&small room		6
10/26/2014	Bldg 31	GE hallway&Union hallway		8
10/28/2014	Bldg 1	Room 151		2
10/30/2014	Building 1	PT-OT halls		3
11/2/2014	Bldg 1	1st floor bathrooms/hall		3
11/3/2014	Bldg 31	Main halls PT-OT area		4
11/9/2014	Bldg 31	in front of elevators/hall		6
11/16/2014	Bldg 31	main lobby/hall to bldg 28		8
11/23/2014	Bldg 1	morgue/ canteen hall		8
12/1/2014	Bldg 31	rms 120/145/dayroom 185		8
12/2/2014	Bldg 31	rms 138/ 167/137		8
12/3/2014	Bldg 31	rms 104/106/102/136		8
12/3/2014	Canteen and	VCS Store		8
12/4/2014	Bldg 31	Rms 114 /123 / 135		8
12/5/2014	Bldg 31	Rms 169/189/190		8
12/7/2014	Bldg 1	BLUE corridor		8
12/8/2014	Bldg 31	Rms 143/150/193		8
12/14/2014	Bldg 1	BLUE corridor completed		8
12/16/2014	Bldg 39	Room 244 Occupational Health		4

3/15/2015	Bldg 39 Back corridor	8
3/16/2015	Bldg 39 Back corridor by exam rooms	8
3/17/2015	Bldg 39 Corridor by rms 108	8
3/18/2015	Bldg 39 last room 131A	8
3/20/2015	Bldg 39 rms 211,212,213,214,211A	8
3/22/2015	Bldg 39 rms 216,217,218	8
3/24/2015	Bldg 39 rms 207,206,218A,218C	8
3/25/2015	Bldg 39 rms 219,218B,205	8
3/26/2015	Bldg 39 rms 218C,220	8
3/27/2015	Bldg 39 rms 221,203,235	8
3/28-29/2015	Canteen Dining room	16
3/30/2015	Bldg 39 rms 223,202,234	8
4/1/2015	Bldg 39 rm 224,226,227	8
4/2/2015	Bldg 39 rms 228,229,230	8
4/6/2015	Bldg 39 rms 231,232, 146a	8
4/10/2015	Bldg 39 rms 237,246,248,249	8
4/12/2015	Bldg 39 white hallways	8
4/14/2015	Bldg 39 rms 200B, 200A	8
4/15/2015	Bldg 39 rms 241,248	8

WHEN WMAF IS COMPLETE

1. ER
2. LAB AREA
3. ICU

Attachment H
Environmental Programs Service Cleaning Frequencies

***Environmental Programs Service (EPS)
Cleaning Frequencies***

The following schedule of cleaning will be followed in patient care areas. Surfaces must be cleaned of any dirt/debris before they can be properly disinfected.

1. **Floors** are vacuumed or dust- and wet-mopped daily.
2. **Wastebaskets** are cleaned as needed. Waste receptacles in clinic areas and non-patient care areas are emptied daily. Filled trash liners are tied close, placed in a collection cart and transported to the waste disposal site. **Never** use hands or feet to compress waste in receptacles.
3. **Regulated Medical Waste (RMW)** containers with a red liner are usually placed in each ward's soiled utility room and other areas as appropriate, and are checked daily.
4. **Bathrooms, showers, utility rooms, toilets, urinals, sinks, mirrors, bathtubs and shower stalls** are cleaned daily. Paper towel dispensers, toilet paper and soap dispensers are checked daily and refilled as needed. Doors and doorframes are cleaned weekly and as needed. Shower curtains are cleaned as soiled.
5. **Furniture**, window sills, ledges, radiators, fire extinguishers, external light fixtures, cubicle curtain tracks, mini-blinds, vents, light covers and horizontal surfaces are cleaned daily by dusting with a vacuum cleaner or specially-treated dust cloth.
6. **Furniture** in patient rooms is washed with an EPA-approved hospital-grade germicide/disinfectant solution as part of the patient discharge procedure and as needed.
7. **Handrails** in corridors are cleaned with an EPA-approved hospital-grade germicide/disinfectant solution weekly and as needed.
8. **Horizontal surfaces** including counter tops, over-bed tables, bedside tables and bed rails are cleaned with an EPA approved hospital grade disinfectant.
9. **Drinking fountains** are cleaned daily and as needed. The exterior and drain tray of ice machines are cleaned as needed.
10. **Patient beds** are cleaned upon discharge or transfer. Exam tables and dialysis treatment chairs are cleaned weekly and as needed.
11. **Long-term care beds** are cleaned monthly when Nursing Service notifies EMS that the patient is out of bed.
12. **Cubicle curtains** are changed when soiled. Draperies and blinds are washed as needed. Damaged curtains or draperies are repaired or replaced. Curtains not soiled and/or damaged will be cleaned using either the Mondo-Vap or Steri-Plex sprayer system.

13. ***Walls and ceilings*** are cleaned as needed, i.e., when visibly soiled.
14. ***Isolation rooms*** are cleaned according to the protocol found in the EPS Procedure Guide.
15. ***Fans*** are cleaned as needed.
16. ***Sharps containers*** are monitored daily and changed as needed by EPS personnel. When boxes are $\frac{3}{4}$ full, they are securely sealed and disposed of as Regulated Medical Waste



ORKIN - ORKIN BURLINGTON, VT
 2 GREEN TREE DR
 S BURLINGTON, VT 05403
 (802) 865-5120

11969172



93801827

GSA/NAME WAS
 163 Veterans Dr
 White River VT
 800-295-9763

E-Mail _____

PRIOR BALANCE: 0
 THIS SERVICE:
 TAX:
 TOTAL AFTER
 THIS SERVICE 0

LRCD:
 GRID:
 ROUTE: 9
 FREQ:

STOP#:

Date 6-6-14 Scheduled Date _____ Prior Service _____
 Time In 1:10 AM/PM
 Time Out 1:50 AM/PM

**This is Your Statement.
 Please Remit The Total Due.**

Amount Paid 0
 Cash
 Check Ck# _____

Pesticide Product Labels are Available Upon Request.
 For additional information, a copy of the Label and/or MSDS may be requested from your local branch.

The type of service performed today was:
 Initial Scheduled No Charge Special Details of this service are listed below.
 Follow Up Service Date _____

CUSTOMER SIGNATURE _____ AM I SATISFIED? YES NO TECHNICIAN SIGNATURE _____

Findings		Treatment						ORKIN COMMERCIAL CUSTOMERS																																					
<input checked="" type="checkbox"/> No activity detected. Performed preventive treatment for target pest(s). <input type="checkbox"/> Ants <input type="checkbox"/> Carpenter Ants <input type="checkbox"/> Fire Ants <input type="checkbox"/> Pharaoh Ants <input type="checkbox"/> Mice <input type="checkbox"/> Rats <input type="checkbox"/> Fleas <input type="checkbox"/> Other <u>Spiders</u>		Orkin takes care to place treatment materials where they will achieve maximum effectiveness. For codes, see other side. <table border="1"> <thead> <tr> <th>Product</th> <th>Quantity</th> <th>Site</th> <th>Specific Site Application Area (if applicable)</th> <th>Method</th> <th>Application Rate</th> <th>Application Rate (if applicable)</th> </tr> </thead> <tbody> <tr> <td colspan="7" style="text-align: center;"><i>[Handwritten scribbles]</i></td> </tr> </tbody> </table>						Product	Quantity	Site	Specific Site Application Area (if applicable)	Method	Application Rate	Application Rate (if applicable)	<i>[Handwritten scribbles]</i>							<table border="1"> <thead> <tr> <th></th> <th>PREVIOUSLY INSTALLED</th> <th># ADDED</th> <th># PICKED UP</th> </tr> </thead> <tbody> <tr> <td>MULTI-CATCH TRAPS</td> <td></td> <td></td> <td></td> </tr> <tr> <td>BAIT STATIONS</td> <td></td> <td></td> <td></td> </tr> <tr> <td>ORIGINAIRE/AIR SCENTS</td> <td></td> <td></td> <td></td> </tr> <tr> <td>FLY TRAPS</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>					PREVIOUSLY INSTALLED	# ADDED	# PICKED UP	MULTI-CATCH TRAPS				BAIT STATIONS				ORIGINAIRE/AIR SCENTS				FLY TRAPS			
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<input type="checkbox"/> Activity detected. Treatment applied for the following: <input type="checkbox"/> Ants <input type="checkbox"/> Carpenter Ants <input type="checkbox"/> Fire Ants <input type="checkbox"/> Pharaoh Ants <input type="checkbox"/> Mice <input type="checkbox"/> Rats <input type="checkbox"/> Fleas <input type="checkbox"/> Other		<input type="checkbox"/> American Roaches <input type="checkbox"/> Brown Banded Roaches <input type="checkbox"/> German Roaches <input type="checkbox"/> Oriental Roaches <input type="checkbox"/> Smokey Brown Roaches <input type="checkbox"/> Crickets <input type="checkbox"/> Spiders <input type="checkbox"/> Stored Product Pests						Are there sanitation and/or storage practice issues? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, see below. Are there structural issues? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, see below. Are there plumbing issues? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, see below. Comments: <u>inspected Am 7-5-14</u> <u>1 Cr. found No body</u> <u>bags on floor wouldn't inspect</u> <u>entire room done to prevent</u>																																					
Your satisfaction is guaranteed. If needed, we will return at no additional charge.		CONSUMER NOTIFICATION(S) / POST APPLICATION STATEMENTS FOR INFORMATION REGARDING CODES LISTED ABOVE, SEE REVERSE SIDE Treated Area(s) - Do not allow unprotected persons, children, or pets to touch, enter, or replace items or bedding; to contact or enter treated areas until dry. Ventilation/Reentry - Vacate and keep areas closed up to 30 minutes after treatment. Once ventilated areas for up to 2 hours before reoccupancy. Equipment/Reentry - Thoroughly wash dishes, utensils, food preparation equipment and surfaces with an effective cleaning detergent and rinse with clean water. If not removed or removed during a treatment, the area should be color free before food products are placed in them. Exterior Applications - (Bait) - Do not allow grazing of food, lawn or seed clippings to re-track after bait applications. Do not burn treated firewood for one month after treatment. Granular Applications - Do not water in the path of row art.																																											

Attachment 1
 Pest Control Receipt

Thank you for your business.

For outdoor application in states where required.				
WIND DIRECTION	WIND VELOCITY	TEMPERATURE	HUMIDITY	SKY CONDITION

National Poison Control Center
 (800) 222-1222

This report does not include wood infesting organisms and/or
 CUSTOMER COPY

State Required Information:

CO - Commercial applicators are licensed by the Colorado Department of Agriculture
 AZ - WARNING: PESTICIDES CAN BE HARMFUL. KEEP CHILDREN AND PETS AWAY FROM PESTICIDES. APPLICATIONS UNTIL DRY, DISSIPATED OR AERATED. FOR MORE INFORMATION, CONTACT: ORKIN PEST CONTROL - CALL AT 1-800-348-7546.
 © 2011 ORKIN LLC 6VPC100WLD Rev. (10/13)

**Attachment J
Call Back Schedule**

MEMORANDUM

Department of Veterans Affairs

Date: January 28, 2015

From: Chief, Pharmacy Service (119)

Subj: Call Back Schedule for Pharmacists Return to Duty

To: Chief, Telecommunication Section (045C); Telephone Operators (07B)

1. Pharmacy's hours of operation: Monday through Friday: 7:00 AM to 11:30 PM
 Saturday and Sunday: 7:00 AM to 11:30 PM (to begin Nov 2014)

2. Call-back duty must be authorized by the Administrative Officer on Duty (AOD).

3. Requests for pharmacist return to duty should be limited to emergent needs, otherwise pharmacy issues should be carried over until the next business day. Virtual Pharmacist should be contacted first with regards to verification of orders, dosing, and drug interaction questions. Off-duty Pharmacists are encouraged to resolve needs by phone to avoid returning to duty.

4. Telephone pharmacists for call-back duty in the order listed for each month until an individual is contacted:

Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015

5. Borrowing/lending and transport of medications to/from the facility **REQUIRES PRIOR AUTHORIZATION BY A PHARMACIST.**

6. For issues relating to security or facilities, contact pharmacy chief [redacted]; 603-448-6149, 603-733-6378 cell.

7. Home telephone numbers are personal information intended for facility use only, and may not be given to unauthorized parties.

Attachment K
Types of Pyxis MedStations

