U.S Office of Special Counsel
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Subject: Response to OSC Investigation file number DI-16-1181

To: John Young

1. Under Specific Allegations of the Whistle blower items 1 and 2 it states that the VA substantiated and did not substantiate the allegations brought forth. It further states that the VA was not able to substantiate allegations when available evidence was not sufficient to support conclusions with reasonable certainty about whether the events or actions took place.

Response: The VA was provided many documents of hard evidence that proved the allegations made were factual and an AIB into the laboratory operations was conducted and the Chief of laboratory was demoted and or stepped down from his position, the laboratory Administrator was detailed out (after the AIB was concluded) as was the lead health technician. Both are still presently detailed out of the laboratory.

2. Under conclusion for Allegation 1 it states that delays in care due to missing lab orders are limited to the time that Veterans spend in the laboratory while Pathology and Laboratory Medicine staff member attempt to determine what tests are required and who should have ordered them.

Response: The delays that are noted in the above do not account for when patients are still in the lab waiting for their blood to be drawn when they should already be at their appointments in their respective clinics.

3. Under conclusion for Allegation 2 it states that the VA substantiated allegations of the lead health technician inappropriately entering test orders under providers' names without proper authority or credentialing and in doing so violated VHA handbook 1106.01 and Medical Center Policy.

Response: The individual noted in Allegation 2 had been noted to have written orders inappropriately for at least three to five years and was very aware that it was a violation of law as she was reported for this violation on more than one occasion and those who reported her activity were assured that she was counseled about her activity and several staff members also made her aware that she was violating policy by writing the orders yet she continued to write orders without authority. I have reason to believe that the laboratory administrator was very aware of the lead technicians order writing activity and even went as far

as to condone it as several of the laboratory employees made the laboratory administrator aware of what was going on and still the activity continued. Incidentally on Dec 18, 2015 after a meeting with upper management there was a conversation between myself, Lisa Wilson, Sharon Pittman and Union President Muriel Newman at which time I mentioned to Ms. Newman about the lead technician writing orders without authorization. Ms. Newman's response was that Denys Krol was an idiot and was transferred from the Lake City laboratory to the Gainesville Laboratory because she was writing orders in Lake City without authorization as well.

4. Under Conclusions for Allegation 2 it states that "in none the subject cases did the VA team find evidence of patient harm resulting from the lead health technician's inappropriate actions.

Response: I do not understand how the agency could have measured this finding given that the agency states (under "findings" paragraph 9 lines 12-15) that the medical center does not have a mechanism to monitor laboratory order cancellations, add-ons, or other order entry functions completed by phlebotomists or technologists if they have entered orders outside of permitted parameters.

5. Under conclusions for allegation 2 it states that medical Center policies and procedures on handling laboratory orders by PLMS contain potentially- conflicting guidance because there are some circumstances where PLMS employees may be required to change, add, or amend orders.

Response: Regardless of policy the lead technician was advised against writing orders without authorization by the other technicians on several occasions. My understanding after reporting to upper management the lead technician was counseled and told not to do this anymore. Even after being counseled she continued to write orders with the last order incident being witnessed and reported by laboratory staff on or around 6 July 2016 (when she wrote lab orders under another employees log in name) which resulted in the lead technician finally being detailed out of the laboratory and stripped of VISTA access altogether. Mind you this happened after the AIB concluded and her inappropriate actions acknowledged by upper management which certainly would have meant that upper management had to have counseled her), The AIB concluded on or around April 16, 2016. The last incident where the lead health technician wrote orders under another persons' log in happened in July which was 3 months after AIB concluded which is an indication that this lead technician will not do what she is told regardless of laws in place to protect the patient.

6. Under recommendations to the medical center item 2 it states "provide supervisory oversight, training and education to the lead health technician on the specific limits related to laboratory order entry authorized for phlebotomists, which prohibits them from entering laboratory orders for providers without their requests."

Response: My supervisor Glenda Skinner had already provided additional education to the phlebotomy staff on merging, cancelling and ordering lab tests and provided the staff with parameters on each and advised the staff not to write orders without authorization from the doctor. This education was provided on more than one

occasion. Additionally no staff what so ever are allowed to take verbal telephone orders from doctors which is VA policy and this was understood by all of the laboratory staff. Additionally please refer back to item 5 above.

7. Under conduct of Investigation it provides a list of people who were interviewed concerning the allegations

Response: they did not interview several employees who have cardinal knowledge of events that occurred by the lead technician that are pertinent to the investigation. Sonia Mitchell, Sandra Johnson, Jordany Simon, Stacey Bradley, and Lisa Wilson. Sonia Mitchell can testify to incidences of "missing specimens while under the care of lead technician as well as writing and cancelling orders, Sandra Johnson can testify to a whole floor of specimens coming up missing after they were handed over to the lead technician, Jordany Simon can testify to specimens coming up missing after being given to the lead technician, Stacey Bradley can testify to the writing of orders and missing specimens, Lisa Wilson can testify to the lead technician writing orders and missing specimens. Also OSC can request from the facility Performance Improvement meeting minutes which identifies "large numbers of missing specimens", (which I provided to the AIB investigators) as many as 223 specimens missing for the month of July 2015 and over 200 missing specimens for the month of August 2015. I and several other lab personnel reported our concerns about sabotage against us by the lead technician on several occasions. Our supervisor at that time Glenda Skinner tried to address the concerns about the possible sabotage and assured me that she would discuss this with her supervisor Merlinda Gomez-Mendez. As of late the issue with respects to missing specimens doesn't seem to be a concern and the majority of missing specimens were coming from specimens that were drawn on the in-patient wards. Respectively since the lead technician has had her VISTA access removed and has been detailed out of the lab the problem with missing specimens has gone away which may be an indication of proof of the other phlebotomists' concerns of sabotage against them by the lead technician.

8. Under "Findings" it states that there were no delays in care of the patient due to orders not being put in the computer by the doctors.

Response: Of course you will not find any delays in surgical care because the lead technician was placing the orders without authorization instead of calling the doctors for orders to be placed which naturally would have prevented delays in patient care.

7. Under "Findings" it states that if there are no orders in the computer for a patient who presents to the lab for blood tests then the phlebotomist is to contact the ordering physician. In the event that the phlebotomist is unable to contact the physician then they must direct the patient to the Emergency Room.

Response: As a phlebotomist who has been in this lab for 5 years I have never been advised on this before and wasn't aware that if we are unable to contact the ordering physician we were to direct patient to the ER. Typically staff (other than the lead technician) who have had difficulty contacting the order physician have been contacting the primary care supervisor who would place the orders for them instead of sending the patient to the ER. One of the biggest problems as to why this is happening is because the laboratory opens much

earlier than the clinics and if orders aren't in when the patient arrives at 0600 hours they typically would have to wait until 0800 hours to get orders placed by the physician in the clinic as the clinics do not open until 0800 hours.

8. Under "Findings", it states that the user profile assigned to phlebotomists does not allow them to enter orders in CPRS nor VISTA.

Response: The laboratory functions provided to phlebotomists does indeed allow them the ability to write and cancel orders; however, this does not mean that we should be using this function. The only instance that I'm aware that we are allowed to use this function is if we accidentally accession the wrong lab order or if we accession an order and was unable to collect the specimen then we would go back into VISTA and cancel the accessioned order and re-order the tests that were not collected. Additionally we would write in the remarks of the cancelled order "wrong order, or unable to obtain".

9. Under "Findings" it states that There are no actions in CPRS for phlebotomists":

Response: I have access to CPRS as does the other phlebotomists. We do not use it though.

10. Under "Findings", paragraph 11 the VA team states that they found substantial evidence to prove that the lead health technician had entered laboratory test orders in several different providers' names. however, they were unable to determine if she was re-entering erroneously deleted orders or amending providers' orders at their request, two permissible actions she is trained and authorized to take or if these orders were entered outside of these parameters.

Response: under "findings" paragraph 12 the VA team states that their concern about these specific laboratory tests is that they were associated with a clinical pharmacist in the anti-coagulation clinic, not a physician and that two of the laboratory orders (Complete Blood count with differential and a Basic Metabolic Panel (which she ordered under the anti-coagulation clinic) are not within the privileges of any pharmacist in the anti-coagulation clinic which would indicate that the orders that the lead technician wrote under anti-coagulation were written "outside of the parameters". Furthermore if the lead technician was re-ordering erroneously deleted orders the VA would have been able to look at the comments under remarks section of the deleted test to see why it was deleted and being re-ordered. All cancelled tests must show a reason for cancellation.

Conclusion for allegation 2 Bullet 3 it states that in none of the subject cases did the VA team find evidence of patient harm resulting from the lead health technicians' inappropriate actions.

Response: How would they know this if they do not have a mechanism to monitor and review the lead technicians' actions.

Overview: I feel that the actions of the lead technician along with the number of years this has been going on with upper management and union president knowledge as well as with the lead technician having been given additional education and staff informing her several times that her actions are illegal any additional education would be redundant and a waste of time. While

I understand that progressive discipline wasn't done over the past 3-5 years and may affect the decision made in this case as an employee and more so as a veteran whose family member receives care at this facility I implore your office to reconsider your recommendation to simply re-educate this lead health technician as opposed to finding her a better suited position elsewhere within the hospital where patient care will not be affected. I further implore that OSC obtain all of the AIB files referencing the laboratory staffs complaints to further determine if there is reasonable cause for removal of both the lead health technician and the laboratory administrator due to concerns that laboratory staff brought forth about possible sabotage of blood specimens by the lead technician.