DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Report to the
Office of Special Counsel
OSC File Number DI-18-2407

Department of Veterans Affairs (VA)
Boston Healthcare System, Brockton Campus
Brockton, Massachusetts

Report Date: September 11, 2018

TRIM 2018-D-1401
Executive Summary

The Executive in Charge of the Office of the Under Secretary for Health requested that the Office of the Medical Inspector assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the Office of Special Counsel (OSC) concerning the VA Boston Healthcare System, Brockton Campus (Brockton) in Brockton, Massachusetts. [Redacted] licensed practical nurse (the whistleblower), who consented to the release of her name, alleged that employees are engaging in conduct that may constitute violations of laws, rules or regulations, gross mismanagement and abuse of authority, which may lead to a substantial and specific danger to public health. VA conducted a site visit to Brockton on May 22–24, 2018.

Specific Allegations of the Whistleblower

1. CLC nursing staff have repeatedly failed to meet agency standards of care, which may constitute a violation of Veterans Health Administration (VHA) Handbook 1142.01, Criteria and Standards for VA Community Living Centers; Charge Nurse Employee 1 and Unit Manager Employee 2 have failed to address the deficiencies in patient care; and

2. Employee 1 instructed [Redacted] to alter an adverse incident report on a patient fall, which may violate VHA Handbook 1050.01, National Patient Safety Improvement Handbook.

We 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. We were 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, we make the following conclusions and recommendations.

Conclusions for Allegation 1

- We substantiate that Community Living Center nursing staff have repeatedly failed to meet agency standards of care which constitutes a violation of VHA Handbook 1142.01. Although we did not find evidence of Veteran harm or neglect (i.e., soiled, full urinals, left abandoned in wheelchairs, empty oxygen cylinders, etc.), or poor performance on Strategic Analytics for Improvement and Learning or Long Term Care Institute reports, we did find two nurses asleep. Despite the lack of Veterans’ suffering, the two sleeping nurses failed to provide a handoff to other nurses on the shift to provide temporary coverage for their assigned Veteran patients in violation of VA Boston Healthcare System Patient Care Memorandum 11-041-LM, and
constituted 50 percent of the available nursing staff on 41C.\textsuperscript{1} We find that this places Veterans in danger as neither individual was immediately available (one was behind a locked door wrapped in a blanket) and both appeared fully asleep upon our discovery.

- We have significant concern about the blatant disregard for Veteran safety by the registered nurses and certified nurse assistants. Short-Stay Skilled Care (provided on unit 41B and 41C) as described in VHA Handbook 1142.02 requires direct interventions by a licensed nurse to meet the complexity of individual Veteran needs. Direct intervention requires the nurse to be present to provide these interventions. As there was no handoff to peers on the unit, this impacted the ability of the covering nurse to provide direct intervention if needed.\textsuperscript{2}

\textbf{Recommendations to Brockton}

1. Take disciplinary actions against the two nurses found sleeping who failed to conduct an appropriate handoff.

2. Implement standards of performance and behavior relating to staff break time and educate the nurse manager and Patient Care Coordinators on appropriate actions to take in the event of violations.

3. Educate staff regarding the standards of performance and behavior relating to break time.

4. Conduct periodic leadership rounds on the off tours at random times (not simply at the beginning or end of the shift).

\textbf{Conclusion for Allegation 2 electronic Patient Event Reports (ePER)}

- We are unable to substantiate that a charge nurse instructed a staff nurse to modify an adverse incident report. We reviewed the completed electronic ePER for the event in question, and found that the content was identical to what was intended and described (i.e., the time of last rounds documented as “unknown”). We found no evidence of coercion or modification of the ePER to reflect a more favorable report.

\textbf{Recommendation to Brockton}

None.

Summary Statement

We have developed this report in consultation with other VHA and VA offices to address OSC's concerns that Brockton may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, which may lead to a substantial and specific danger to public health and safety. In particular, VHA Human Resources has examined personnel issues to establish accountability, and the National Center for Ethics in Health Care has provided a health care ethics review. We found violations of VHA policy, and note that a substantial and specific danger to public health and safety exists at Brockton.
Executive Summary........................................................................................................ ii
I. Introduction ................................................................................................................ 1
II. Facility Profile ........................................................................................................... 1
III. Specific Allegations of the Whistleblower ............................................................. 1
IV. Conduct of Investigation ....................................................................................... 1
V. Findings, Conclusions, and Recommendations .................................................. 3

Allegation 1 ...................................................................................................................... 3

CLC nursing staff have repeatedly failed to meet agency standards of care, which may constitute a violation of Veterans Health Administration (VHA) Handbook 1142.01, Criteria and Standards for VA Community Living Centers; Charge Nurse [Employee 1] and Unit Manager [Employee 2] have failed to address the deficiencies in patient care

Background .................................................................................................................... 3
Findings .......................................................................................................................... 4
Conclusions for Allegation 1 ........................................................................................ 7
Recommendations to the Medical Center ...................................................................... 8

Allegation 2 ...................................................................................................................... 8

[Employee 1] instructed [REDACTED] to alter an adverse incident report on a patient fall, which may violate VHA Handbook 1050.01

Background .................................................................................................................... 8
Findings .......................................................................................................................... 9
Conclusions for Allegation 2 ........................................................................................ 9
Recommendation to Brockton ....................................................................................... 9

VI. Summary Statement .............................................................................................. 9
Attachment A ................................................................................................................ 10
I. Introduction

The Executive in Charge of the Office of the Under Secretary for Health 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 VA Boston Healthcare System (HCS), Brockton Campus (Brockton) in Brockton, Massachusetts. [redacted] (the whistleblower), a licensed practical nurse (LPN), who consented to the release of her name, alleged that employees are engaging in conduct that may constitute violations of laws, rules or regulations, gross mismanagement and abuse of authority, which may lead to a substantial and specific danger to public health. We conducted a site visit to Brockton on May 22–24, 2018.

II. Facility Profile

VA Boston Healthcare System, a part of Veterans Integrated Service Network (VISN) 1 consists of three main campuses in Brockton, Jamaica Plain, and West Roxbury, with five community based outpatient clinics in Lowell, Quincy, Framingham, Plymouth, and Boston. The West Roxbury Campus serves as the principal tertiary inpatient medical center for Veterans throughout New England. The Brockton Campus provides a full spectrum of acute and chronic inpatient, residential, and outpatient mental health services, short-term rehabilitation and medical care, palliative and hospice care, long-term care, a chronic spinal cord injury unit, and comprehensive primary care. There is also an inpatient psychiatric unit for women and a residential rehabilitative unit for women affected by post-traumatic stress syndrome and substance abuse.

III. Specific Allegations of the Whistleblower

1. CLC nursing staff have repeatedly failed to meet agency standards of care, which may constitute a violation of Veterans Health Administration (VHA) Handbook 1142.01, Criteria and Standards for VA Community Living Centers; Charge Nurse Employee 1 and Unit Manager Employee 2 have failed to address the deficiencies in patient care; and

2. Employee 1 instructed [redacted] to alter an adverse incident report on a patient fall, which may violate VHA Handbook 1050.01, National Patient Safety Improvement Handbook.

IV. Conduct of Investigation

The VA team conducting the investigation consisted of the Chief Medical Investigator and a Clinical Program Manager, both of OMI, and an Employee Relations/Labor Relations Specialist, Bay Pines VA Healthcare System (virtual). We reviewed relevant policies, procedures, professional standards, reports, memoranda, and other documents listed in Attachment A, toured Brockton's Community Living Center (CLC).
units and Urgent Care Center (UCC), and held entrance and exit briefings with leadership.

Brockton entrance brief attendees:

- Acting Director, VISN 1
- Acting Chief Medical Officer, VISN 1
- Geriatric and Extended Care (GEC) Director, VISN 1
- Director of Quality/Performance Management, VISN 1
- Medical Center Director (MCD)
- Deputy MCD
- Assistant MCD
- Associate Director Nursing/Patient Care Services
- Deputy Nurse Executive
- Director of Quality Management (QM)
- Chief of Staff
- Associate Chief Nursing Service, Clinical Ops
- Health Services Specialist

Brockton exit brief attendees:

- Acting Director, VISN 1
- Acting Chief Medical Officer, VISN 1
- GEC Director, VISN 1
- Director of Quality/Performance Management, VISN 1
- MCD
- Deputy MCD
- Assistant MCD
- Associate Director Nursing/Patient Care Services
- Deputy Nurse Executive
- Director, QM
- Associate Chief Nursing Service, Clinical Ops
- Mental Health Nurse
- Chief, GEC Service
- Medical Director, CLC
- Health Services Specialist

We attempted to schedule an interview with the whistleblower prior to the site visit but were unable to contact her. We interviewed her once on site. We also interviewed the following Brockton employees:

- Associate Director of Nursing/Patient Care Services
- Chief, Geriatrics and Extended Care Service
- Medical Director, CLC
- Nurse Manager, CLC Units 41B & 41C
• Chief, QM/Risk Management
• QM Specialist
• Two Patient Care Coordinators (PCC)
• Two Registered Nurses (RN), 41C
• Two RNs 42C
• Two RNs, 41B
• RN, 42B
• RN, Spinal Cord Injury Unit
• Two LPNs, 41C
• LPN, 42B
• The whistleblower, LPN
• Two LPNs, 41B
• LPN, 42C
• Certified Nurse Assistant (CNA) 42B
• CNA-A, CNA-B; Two CNAs 41C

V. Findings, Conclusions, and Recommendations

Allegation 1

CLC nursing staff have repeatedly failed to meet agency standards of care, which may constitute a violation of Veterans Health Administration (VHA) Handbook 1142.01, Criteria and Standards for VA Community Living Centers; Charge Nurse Employee 1 and Unit Manager Employee 2 have failed to address the deficiencies in patient care.

Background

VHA Handbook 1142.01 describes CLCs as providing skilled nursing accompanied by a variety of specialty programs for Veterans needing both short-stay, as well as long-stay services. The Handbook states that the provision of services within CLCs is to be consistent with the long-term standards set forth by The Joint Commission (TJC) and are to be periodically evaluated by the Long Term Care Institute (LTCl) using both TJC and Centers for Medicare and Medicaid Services (CMS) criteria. The Handbook identifies short-stay services as those for an expected length of stay of 90 days or less, and long-stay services as those for an expected length of stay of more than 90 days. The Brockton CLC has six different care specialties: Short-Stay Rehabilitation, Short-Stay Skilled Nursing Care, Short-Stay Restorative Care, Short-Stay Continuing Care, Hospice and Palliative Care, and Long-Stay Continuing Care. These are provided in Building 4 on Short-Stay (transitional care) units 41B, 41C, and in Long-Stay units 42B (dementia) and 42C (hospice). A major component of Short-Stay Skilled nursing care defined by the Handbook includes "...interventions that require the involvement of a Registered Nurse (RN) or licensed nurse (Licensed Practical Nurse

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3 VHA Handbook 1142.01, Criteria and Standards for VA Community Living Centers, August 13, 2008.
4 VHA Handbook 1142.02, Admission Criteria, Service Codes, and Discharge Criteria for Department of Veterans Affairs Community Living Centers, September 2, 2012.
(LPN) or Licensed Vocational Nurse (LVN)) on a daily basis." Its examples of short stay skilled nursing services include but are not limited to: intravenous therapy, care of stages 3 and 4 pressure ulcers, complex wound care, ventilator care, suctioning, tracheotomy care, tube feeding, and other interventions where the complexity of Veteran needs requires direct intervention by a licensed nurse.

Nursing-sensitive indicators are a series of metrics that reflect the structure, process, and patient outcomes of nursing care. Structure includes the supply, skill level, and education of the nursing staff; process includes assessment, intervention, and job satisfaction; and outcomes are patient outcomes that improve if there is greater quantity and quality of nursing care. VHA monitors nursing-sensitive indicators including nursing hours per patient day (NHPPD), patient falls with injury, and hospital-acquired pressure ulcer (HAPU) rates, among other elements.

TJC describes a hand-off as: "...a transfer and acceptance of patient care responsibility achieved through effective communication. It is a real-time process of passing patient-specific information from one caregiver to another or from one team of caregivers to another for the purpose of ensuring the continuity and safety of the patient's care." The handoff should include a brief assessment of the patient's condition and history, an action list, and contact information for the person providing the handoff.

Findings

We reviewed the Strategic Analytics for Improvement and Learning (SAIL) data, and found HAPU rates in the lower quintile (i.e., worse) compared to CLC peers, and a patient fall with injury rate in the middle quintile (i.e., average), a level at which it has remained since the first quarter of Fiscal Year (FY) 2014. Of note, SAIL overall staffing for the Brockton CLC received the highest rating of five stars, with the average NHPPD exceeding both the case mix adjusted and the national CMS hours per patient day. We also analyzed the Nurse Staffing Methodology and found that between FYs 2016 and 2017 there had been a change in the patient admission profile from Long-Stay Care to Short-Stay Care, requiring adjustments to the NHPPD on unit 41B, and the addition of two restorative therapy aides for building 4. This change was in response to the increasing demand for acute inpatient care at West Roxbury, and the need to transfer subacute Veterans to other facilities such as Brockton to meet demand. Brockton designated units 41B and 41C as subacute care, and changed the types of Veterans from long-term care to short-term and rehabilitation care. These subacute care

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5 Ibid.
Veterans require more advanced interventions (tracheostomy care, complex wound care, and enteral feeding, for example) that result in more nursing interventions. In FY 2017, Brockton unit 41B had the lowest NHPPD of the CLCs in VA Boston HCS, despite the change in the types of Veterans cared for on the unit. In FY 2018, units 41B and 41C saw NHPPD increase from 5.3 to 5.8.

Brockton had a LTCl survey conducted from August 15–17, 2017, that found three separate concerns regarding Veteran care: pain management, infection control practices during a dressing change, and management of a Veteran's gastrostomy tube. There were no trends reported.

We interviewed RNs, LPNs, and CNAs from the day, evening, and night shifts, and PCCs who serve as Nursing Service supervisors on the evening, night, holiday, and weekend shifts. One indicated general concerns, such as excessive falls attributed to inattentive or unavailable staff, and one indicated that changes in staffing patterns resulted in an increase in falls due to increasing complexity and inadequate nursing staff. As indicated above, SAIL data on patient falls with injury has not changed since FY 2014, and is in the middle quintile of CLC peers.

None of the other nursing or physician staff expressed concerns over Veteran care. Nurses conduct hourly rounds on the Veterans, and document completion on a locally-developed flow sheet. The task of rounding is shared among the staff members on duty, with each member assigned specific hours on the shift. This flow sheet includes the individual Veteran’s location at the time (bedroom, dining room, off ward, hallway, bathroom, therapy, day room, or appointment). This documentation is shredded after 2 months, according to local policy. We reviewed a sample of the available flow sheets from March 21 through April 6, 2018, and found initials missing on one night shift of a one-hourly check, and several instances where it appeared that two different individuals documented during the same time period; one documenting Veteran location (CNA-A) and the other signing off completion of the hourly task (CNA-B). Brockton also provided an investigation conducted by the QM Specialist related to similar concerns: he found a 98 percent compliance rate with rounding documentation; however, he similarly observed two individuals documenting at the same time, although only one was assigned. This investigation involved direct inspection of Veteran rooms and interviews with available Veterans, but was conducted at the end of the night shift (starting at 6:00 a.m.). As a result, the findings might not represent the conditions in the middle of the shift.

We identified a pattern indicating CNA-B failed to document the Veteran’s location in six out of eight instances, but did sign indicating completed rounds as noted above, consistent with the observations of the QM Specialist’s report. We reviewed electronic Patient Event Reports (ePER) for FY 2017 through May 17, 2018, and found none associated with the dates of the missing documentation.

OSC’s referral letter identified three different cases of concern. The first involved a Veteran found by a nurse to be short of breath and with an empty oxygen tank. We
were able to locate this Veteran's medical record in the Veterans Information Systems and Technology Architecture (VistA) and the incident report related to this concern. This Veteran transferred from West Roxbury to unit 41C on \textbf{Patient 1} 2018, having been on oxygen at two liters per minute via nasal cannula while at West Roxbury, with the last oxygen saturation documented there as 94 percent on supplemental oxygen. The transfer orders to Brockton included no order for oxygen. On \textbf{Patient 1}, 2018, at approximately 2:20 a.m., an oxygen order was written at the rate indicated above. There is no clinical change that prompted this addition, but it is likely a result of a routine 24-hour chart check by nursing staff identifying and correcting a discrepancy. From \textbf{Patient 1} to \textbf{Patient 2}, the Veteran's vital signs show an oxygen saturation of 94-96 percent on room air. On \textbf{Patient 1}, the night shift nurse noted that the Veteran was short of breath and did not have the previously ordered nasal cannula in place. The nurse measured the Veteran's oxygen saturation at 78 percent, and attempted to apply oxygen as ordered on \textbf{Patient 1}, but found the tank empty. The nurse replaced the oxygen tank and subsequently monitored the Veteran. His oxygen saturation improved to 91 percent later in the shift. We reviewed notes on the following 2 days, which included an assessment by a cardiologist, and found no evidence of adverse sequelae related to low oxygen saturation.

Veterans A and B, identified in the OSC referral, suffered falls nearly simultaneously on the night of \textbf{Patients A and B} 2018, but neither resulted in long-term sequelae according to the VistA records. Veteran A required transfer to a local emergency department for radiology studies, and then to West Roxbury for hospitalization. He returned to Brockton following 2 days as inpatient at West Roxbury to assess for gait instability related to his fall and further assessment of his known Parkinson's disease. Veteran B refused transport to the hospital. The physician on duty in the UCC evaluated both Veterans shortly after their falls. In the ePER, a nursing staff member indicated that Veteran B had inadvertently disconnected his gastrostomy tube feeding. According to the ePER, when he stood up to go to the restroom he presumably slipped in the tube feed liquid on the floor; however, the fall was unwitnessed. The tube feeding was at a constant rate administered by a pump in milliliters per hour. The nurse indicated that there was a large amount of liquid on the floor when she arrived, which indicated that the gastrostomy tube had been disconnected for over an hour. She based her assessment on the number of milliliters per hour set on the pump, and the amount of liquid on the floor. The implication was that nursing staff had not rounded on Veteran B in significantly more than an hour. We reviewed the nurse assignment sheets for this date and the VistA record and found CNA-B was assigned to both this shift and Veterans A and B. We were unable to determine completion of rounds from the flowsheet because the event occurred in \textbf{Patients A and B} 2018, and flowsheets from that time had been shredded in accordance with the local policy.

One person reported witnessing nursing staff sleeping on the night shift; however, others denied witnessing this behavior. The staff member stated that on at least one occasion CNA-B was assigned to assist with care for a “two person assist” Veteran and

\footnote{Not all the rooms on 41C have wall oxygen and rely on portable tanks only if the Veteran cannot be moved to another room with wall oxygen.}
could not be located. CNA-B was also the same as the one who failed to complete the hourly rounding flowsheet appropriately as discussed above. We conducted an unannounced visit to units 41C and 41B at approximately 2:40 a.m. on May 24, 2018, accompanied by the PCC on duty, who met us in the UCC. When we arrived on unit 41C, we found two individuals at the nurse’s station (in the center of the unit) and asked them about the number of staff on duty, as well as their current locations. They told us there were two additional staff on duty (a total of four), but they could not account for their whereabouts or status. Brockton uses a commercial device (Vocera) for intrafacility communication, which allows individual staff members to communicate directly with each other through a wearable device, making knowledge of someone’s location less of an issue. However, VA Boston Healthcare System Patient Care Memorandum (PCM) 11-041-LM requires hand-off communication to assign temporary responsibility for staff leaving the unit for a short time such as breaks or lunch among other situations. TJC recommendation on handoff provides a basic structure for the content of the handoff which includes a brief overview of all patients to ensure continuation of care in the primary nurses’ absence.

We inspected all Veterans’ rooms, finding no obvious signs of neglect, or any patients in need of nursing care or assistance (i.e., disheveled, inappropriately positioned in bed, or wandering). We also reviewed nursing staff daily assignment sheets for the unit, which indicate the RNs’, LPNs’, and CNAs’ daily assignments for tasks, rooms, and individual Veterans, and found no indication of scheduled breaks for any of the shifts listed. During the course of the inspection, we found the two missing staff members asleep in unlit rooms in two different locations; one (an RN) in the day room with a room divider partially closing off her location, and the second (CNA-B) in the locked dining room wrapped in a blanket; both were on rearranged chairs. Neither had been contacted via Vocera by their peers in an attempt to locate them or advise them of our presence. In both cases, the PCC’s first question to them was, “Are you on break?” This question appeared to us as an effort to both awaken them and provide a plausible explanation for their behavior. Both responded with something similar to, “I'm on break.” During interviews many nurses in supervisory roles on the units, including the nurse manager of both 41B and 41C, told us that staff were not restricted on what they could do while on break. However, since the staff at the central nurses’ station had no knowledge of the location or status of the nurses we found sleeping, no handoff had occurred with the nurses who would be responsible for providing care for Veterans in their absence.

Conclusions for Allegation 1

- We substantiate that CLC nursing staff have repeatedly failed to meet agency standards of care which constitutes a violation of VHA Handbook 1142.01. Although we did not find evidence of Veteran harm or neglect (i.e., soiled, full urinals left abandoned in wheelchairs, empty oxygen cylinders, etc.), or poor performance on

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SAIL or LTCI reports, we did find two nurses asleep. Despite the lack of Veterans' suffering, the two sleeping nurses failed to provide a handoff to other nurses on the shift to provide temporary coverage for their assigned Veteran patients in violation of VA Boston Healthcare System PCM 11-041-LM, and constituted 50 percent of the available nursing staff on 41C. We find that this places Veterans in danger as neither individual was immediately available (one was behind a locked door wrapped in a blanket) and both appeared fully asleep upon our discovery.

- We have significant concern about the blatant disregard for Veteran safety by the RN and CNA-B. Short-Stay Skilled Care (provided on unit 41B and 41C) as described in VHA Handbook 1142.02 requires direct interventions by a licensed nurse to meet the complexity of individual Veteran needs. Direct intervention requires the nurse to be present to provide these interventions. As there was no handoff to peers on the unit, this impacted the ability of the covering nurse to provide direct intervention if needed.\(^\text{13}\)

Recommendations to Brockton

1. Take disciplinary actions against the two nurses found sleeping who failed to conduct an appropriate handoff.

2. Implement standards of performance and behavior relating to staff break time and educate the nurse manager and PCCs on appropriate actions to take in the event of violations.

3. Educate staff regarding the standards of performance and behavior relating to break time.

4. Conduct periodic leadership rounds on the off tours at random times (not simply at the beginning or end of the shift).

Allegation 2

Employee 1 instructed [redacted] to alter an adverse incident report on a patient fall, which may violate VHA Handbook 1050.01.\(^\text{14}\)

Background

VHA Handbook 1050.01, states the goal of the Patient Safety Program is to prevent harm to patients by identifying and reporting adverse events and close calls, reviewing adverse events and close calls to identify underlying causes and implementing changes needed to reduce the likelihood of recurrence, and disseminating patient safety alerts.

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and lessons learned.\textsuperscript{15} When an adverse event or close call occurs, VA personnel may use any available or locally accepted method to notify the patient safety manager and begin the facility's consideration of the event. There is no requirement to get approval from management or leadership before reporting an adverse event or close call.

Findings

We interviewed nurses from all shifts and physicians responsible for care of Veterans on units 41B, 41C, 42B, and 42C. All indicated that there were no barriers to reporting concerns through the ePER process or directly to management. The whistleblower indicated that an employee, a charge nurse, instructed her to modify an ePER, specifically the section, "Time Patient was last Rounded prior to his/her fall," which the writer had documented as "unknown." The whistleblower stated that she believed the intent was to change this specific section to "5 minutes prior" to imply staff had rounded on the Veteran more recently than indicated by the evidence. In her interview, who is named in the allegation, denied instructing anyone to change an incident report. We also reviewed the ePER and found that the document contained the statement "unknown," which was what the writer described.

Conclusion for Allegation 2

• We are unable to substantiate that a charge nurse instructed a staff nurse to modify an adverse incident report. We reviewed the completed ePER for the event in question, and found that the content was identical to what was intended and described (i.e., the time of last rounds documented as "unknown"). We found no evidence of coercion or modification of the ePER to reflect a more favorable report.

Recommendation to Brockton

None.

VI. Summary Statement

We have developed this report in consultation with other VHA and VA offices to address OSC's concerns that Brockton may have violated law, rule or regulation, engaged in gross mismanagement and abuse of authority, which may lead to a substantial and specific danger to public health and safety. In particular, VHA Human Resources has examined personnel issues to establish accountability, and the National Center for Ethics in Health Care has provided a health care ethics review. We found violations of VHA policy, and note that a substantial and specific danger to public health and safety exists at Brockton.

\textsuperscript{15} Ibid.
Attachment A

Documents in addition to the Electronic Medical Records reviewed:


Strategic Analytics for Improvement and Learning (SAIL) for Brockton CLC.

Long Term Care Institute (LTCI) Survey results from 2017 for Brockton CLC.


All Event reports (ePERs) for CLC units FY 2017 through May 17, 2018.

Nurse Staffing Methodology data for CLC units, FYs 2017 and 2018.

Nursing Sensitive Indicator reports for CLC units, FYs 2017 and 2018 (most recent).

All Veteran complaints, January to May 2018.

Internal Quality Management investigation for CLC concerns.

Geriatrics and Extended Care meeting minutes FY 2017.

Nursing Assignment sheet for 41C February 2018.
CLC Hourly rounding flow sheets March and April 2018.

Various emails provided by nurse manager.
Attachment A

Documents in addition to the Electronic Medical Records reviewed:


TJC Sentinel Event Alert Inadequate hand-off communication, Issue 58, September 12, 2017; [https://www.jointcommission.org/assets/1/18/SEA_58_Hand_off_Comms_9_6_17_FINAL_1_.pdf](https://www.jointcommission.org/assets/1/18/SEA_58_Hand_off_Comms_9_6_17_FINAL_1_.pdf).


Strategic Analytics for Improvement and Learning (SAIL) for Brockton CLC.

Long Term Care Institute (LTCl) Survey results from 2017 for Brockton CLC.


All Event reports (ePERs) for CLC units FY 2017 through May 17, 2018.

Nurse Staffing Methodology data for CLC units, FYs 2017 and 2018.

Nursing Sensitive Indicator reports for CLC units, FYs 2017 and 2018 (most recent).

All Veteran complaints, January to May 2018.

Internal Quality Management investigation for CLC concerns.

Geriatrics and Extended Care meeting minutes FY 2017.

Nursing Assignment sheet for 41C February 2018.
CLC Hourly rounding flow sheets March and April 2018.

Various emails provided by nurse manager.