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The Special Counsel

October 23, 2018

The President
The White House
Washington, D.C. 20500

Re: OSC File No. DI-18-2407

Dear Mr. President:

Pursuant to my duties as Special Counsel, I am forwarding to you a report provided to me in response to disclosures received from an employee at the Department of Veterans Affairs (VA), VA Boston Healthcare System, Community Living Center (CLC), Brockton, Massachusetts. The whistleblower, [redacted] who consented to the release of her name, is a former licensed practical nurse with the Brockton CLC. [redacted] alleged that CLC nursing staff in short-term care neglected patient needs and failed to provide required assistance with essential care. I have reviewed the report, and in accordance with 5 U.S.C. § 1213(e), I provide the following summary of the agency investigation and my findings.[1]

[redacted] reported that CLC nursing staff repeatedly failed to meet agency standards of care, as required by Veterans Health Administration (VHA) Handbook 1142.01. When [redacted] began working at the CLC in December 2017, she observed significant neglect of patients. She asserted that nurses and certified nursing assistants (CNAs) failed to make rounds to check on patients and failed to provide required assistance for essential care. [redacted] further alleged that a CLC charge nurse instructed her to alter an adverse incident report on a patient fall to indicate that CLC nursing staff checked on the patient five minutes prior to the event. Overall, [redacted] expressed great concern regarding the lack of quality care provided to patients.

The agency substantiated [redacted] allegation that CLC nursing staff failed to meet agency standards of care, in violation of VHA Handbook 1142.01. Although the investigation did not find evidence of patient harm or neglect, it did uncover issues of inadequate hand-off communication amongst nursing staff. During a site visit, investigators found a registered nurse (RN) and CNA asleep while on duty. The report stated that the two sleeping nurses failed to provide a hand-off to other nurses on shift to ensure temporary coverage for their assigned patients. Further, the report expressed, "significant concern about the blatant disregard for [patient] safety by the RN and CNA-B." The type of care provided on these CLC units requires direct intervention by a licensed nurse to meet the complexity of the

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[redacted] allegations were referred to then-VA Acting Secretary Robert L. Wilkie on March 29, 2018 pursuant to 5 U.S.C. §1213(c) and (d). The authority to investigate the matter was delegated to VA's Office of the Medical Inspector. Secretary Wilkie reviewed and signed the agency's report. [redacted] did not comment directly on the report.

patients' needs. As there was no hand-off, the sleeping nurses impeded the ability of the covering nurse to provide direct intervention, if needed.

The investigation did not substantiate [redacted] second allegation that a charge nurse instructed her to modify an adverse incident report. OMI reviewed the completed electronic record for the event in question and found that the content was identical to what was intended and described. The investigation did not find evidence of coercion or modification of the electronic record to reflect a more favorable report.

In response to these findings, OMI recommended that the agency take disciplinary action against the two nurses found sleeping who failed to conduct appropriate hand-offs. Further, the agency suggested that CLC nursing leadership conduct periodic rounds on the off hours at random times to ensure nursing staff is available to provide direct intervention if needed.

[redacted] declined to comment directly on the agency's findings. However, she stated that due to the lack of respect for patient care and the retaliatory culture within the CLC, she chose to resign from her position in July 2018.

I have reviewed the original disclosure and the agency report and have determined that the report contains the information required by statute, and the findings appear reasonable. While the allegations reported by [redacted] were very concerning, I am encouraged by the efforts made by the agency to ensure that the CLC patients will receive quality care.

I am concerned, however, that [redacted] felt that she needed to resign from her position due to the retaliatory environment created at the Brockton CLC. I strongly urge the agency to take appropriate measures to ensure that personnel who raise issues of patient care do not experience retaliation.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of this letter and the agency report to the Chairmen and Ranking Members of the Senate and House Committees on Veterans Affairs. I have also filed redacted copies of these documents and a redacted copy of the referral letter in our public file, which is available online at www.osc.gov, and closed the matter.

Respectfully,

Henry J. Kerner
Special Counsel

Enclosure