U.S. OFFICE OF SPECIAL COUNSEL
1730 M Street, N.W., Suite 300
Washington, D.C. 20036-4505

The Special Counsel

December 7, 2012

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

Re: OSC File No. DI-11-0048

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), please find enclosed a report received from the Honorable Eric K. Shinseki, Secretary of Veterans Affairs, in response to disclosures made by a whistleblower alleging that employees at the Department of Veterans Affairs (VA), Togus VA Medical Center (Togus VA), Augusta, Maine, engaged in conduct that constituted gross mismanagement and a substantial and specific danger to public health and safety. Specifically, the whistleblower alleged that Togus VA staff failed to follow the proper procedure for transferring patients from one caregiver to another. The whistleblower chose to remain anonymous.

The allegations were referred to Secretary Shinseki on March 15, 2011. The Secretary tasked the Under Secretary for Health with the review of this matter; the Under Secretary directed the Office of the Medical Inspector (OMI) to investigate the allegations and report on the findings. Secretary Shinseki transmitted the report to the Office of Special Counsel (OSC) on July 1, 2011. The whistleblower did not comment on the report.

The allegations were not substantiated; however, the OMI recommended that Togus VA staff receive additional training on Inpatient Rapid Response Teams (IRRT). The Secretary noted that Togus VA will develop an action plan in response to this recommendation and the OMI will monitor the plan until its completion. A brief summary of the allegations and the VA's report follows. I have determined that the agency's findings appear reasonable.

The Office of Special Counsel (OSC) is authorized by law to receive disclosures of information from federal employees alleging violations of law, rule, or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health and safety. 5 U.S.C. § 1213(a) and (b). OSC does not have the authority to investigate a whistleblower's disclosure; rather, if the Special Counsel determines that there is a substantial likelihood that one of the aforementioned conditions exists, she is required to advise

the appropriate agency head of her determination, and the agency head is required to conduct an investigation of the allegations and submit a written report. 5 U.S.C. § 1213(c) and (g).

Upon receipt, the Special Counsel reviews the agency report to determine whether it contains all of the information required by statute and that the findings of the head of the agency appear to be reasonable. 5 U.S.C. § 1213(e)(2). The Special Counsel will determine that the agency's investigative findings and conclusions appear reasonable if they are credible, consistent, and complete based upon the facts in the disclosure, the agency report, and the comments offered by the whistleblower under 5 U.S.C. § 1213(e)(1).

Background

The initial report submitted to OSC on July 1, 2011, omitted the names of VA employees interviewed and referred to employees by title only. The agency did not provide a legal basis for the omission of the employee names as is customary under OSC's accommodation policy when agencies redact the names of their employees. Under OSC's accommodation policy, instituted in April 2011, OSC allows the agency to redact employee names from the report available in OSC's public file, but notes its objection to the redaction on the basis that the public has an interest in knowing the names of those federal employees involved. The agency provides an unredacted report for transmittal to you, Chairmen and Ranking Members of the Senate Committee on Veterans' Affairs and the House Committee on Veterans' Affairs, and the whistleblower.

In July 2011 and continuing through 2012, the VA declined to follow the accommodation policy and objected to the inclusion of employee names in its reports. As a result, in many cases the VA provided a report containing only employee titles. In an attempt to address the agency's concerns and OSC's objections, OSC staff met with VA Office of General Counsel staff on April 13, 2012. No agreement was reached at that meeting, but the agency indicated that that OSC would be notified of the VA's final determination on the matter by June 11, 2012. The agency was aware that, while awaiting the VA's response, OSC was delaying the transmission of reports to you and Congress. When the VA failed to respond by June 11, 2012, discussions among OSC, VA General Counsel staff, and the White House Counsel's Office ensued. On August 30, 2012, OSC reached an agreement with the VA, wherein, for all future matters, the VA will provide OSC with an unredacted report containing employee names and titles for you, Congress, and the whistleblower, and a redacted report, containing employee titles only, for OSC's public file. For pending matters, such as this one, the VA provided a revised report containing employee names and titles. OSC received the revised report in this case on October 11, 2012. The whistleblower was given the opportunity to comment on the revised report but declined.

The Whistleblower's Allegations

The whistleblower alleged that the nurses at Togus VA frequently failed to follow the proper "handoff" procedure when transferring a patient from one caregiver to another. The whistleblower explained that when a patient is transferred, the nurse relinquishing care of the patient is required to provide the patient's pertinent medical information to the nurse assuming

care. Caregivers are to follow a standardized handoff procedure that the whistleblower noted follows a format known as SBAR: situation, background, assessment, and recommendation. The whistleblower reported that from approximately January to September 2010, patients were routinely transferred to the medical-surgical ward, 3 North, without the necessary handoff information being communicated to the nurse assuming care for the patient. The whistleblower alleged that the failure to provide the SBAR information jeopardized patient care, especially in medical-surgical wards, such as 3 North, because patients recovering from surgery may have more urgent care needs.

The whistleblower noted one incident in particular, which occurred on September 24, 2010, involving a patient transferred to 3 North after a surgical procedure to insert a pacemaker. The whistleblower alleged that the patient was left on the ward without a complete handoff and, as a result, the nurses assuming care for the patient were unaware that his blood pressure was dangerously elevated and that he was potentially unstable. The whistleblower reported that the 3 North Nurse Unit Manager was aware of the incomplete handoff in this case and others.

The whistleblower alleged that in a separate incident on 3 North, the physician on duty failed to respond to a rapid response alarm, which notifies medical personnel to respond to a medical emergency. The whistleblower reported that on September 16, 2010, a patient mentally deteriorated and suddenly became unresponsive. A rapid response alarm was triggered and according to the whistleblower, the physician on call, respiratory therapist, charge nurse, patient care coordinator, nurse assigned to the patient, nurse unit manager, and a phlebotomist were required to respond. The whistleblower explained that due to the efforts of the nurses present the patient regained consciousness; however, his mental state was still diminished. The whistleblower disclosed that neither the physician nor the Nurse Unit Manager responded. When the physician failed to respond, most of the medical personnel who had responded left the patient and returned to their other duties. Nursing staff remained with the patient.

After approximately two hours, the physician on duty called the room and ordered that the patient be transferred to the Intensive Care Unit. The whistleblower explained that laboratory results indicated that the patient had suffered a heart attack because his level of Troponin, a cardiac enzyme, was elevated. The whistleblower contended that the physician's failure to respond timely to the rapid response alarm delayed critical treatment for nearly two and a half hours and may have been a significant factor in the patient's death two days later. Finally, the whistleblower alleged that the physician's failure to respond was a violation of VA policy and that the incident should have been reported as a sentinel event.[1]

The Report of the Department of Veterans Affairs

The OMI team included the Medical Inspector and a Medical Investigator, both physicians. The team visited the Togus VA and toured the inpatient medical-surgical unit, interviewed

[1]A sentinel event is defined as an adverse event that results in the loss of life or limb or permanent loss of function. 38 C.F.R. § 52.120.

approximately 28 staff members, and reviewed VA and facility policies and procedures as well as relevant medical documentation.

The OMI report describes handoff as the "process of transferring responsibility of care for a patient from one caregiver to another to ensure patient safety and continuity of care." Handoff communication is required when there is a change in caregivers, i.e., a transfer to another ward, a change of shift, and when there is a change in the condition of the patient. The report states that the Joint Commission[2] requires a standardized approach for handoff communication. To meet this requirement, the VA's National Center for Patient Safety developed a standardized guide that incorporates the SBAR format.

With respect to the September 24, 2010 incident, the investigation determined that when the patient met the criteria for post-surgical discharge, the Post Anesthesia Care Unit (PACU) nurse gave a handoff report by telephone to the nurse assuming care for the patient on the medical-surgical floor. Investigators reviewed the medical record and interviewed the PACU nurse. The receiving nurse is no longer employed at the Togus VA and could not be interviewed. The OMI team concluded that the handoff communication met the requirements of the SBAR format and was properly documented in the medical record. Thus, the investigation did not substantiate the allegation that Togus VA staff failed to follow proper handoff procedure.

The OMI report acknowledges that the Nurse Manager was aware of the receiving nurse's concern that the handoff did not follow the SBAR format and, therefore, was inadequate. The OMI team found that the Nurse Manager properly investigated the incident by reviewing the handoff documentation for the patient and speaking to both nurses. The report states that the Nurse Manager reviewed the medical records of other veterans transferred and spoke to additional nursing staff about handoff procedures and communications. The Nurse Manager did not find any evidence that staff were not using the SBAR format for patient transfers. The OMI reviewed the medical records of 20 veterans transferred to or from the medical-surgical unit during September and October 2010 for handoff documentation. The report explains that even though there is no requirement to document the use of SBAR during patient handoff, 70 percent of the medical records reviewed contained documentation indicating SBAR procedures were used. Further, the OMI interviewed 14 bedside nursing staff who all stated they were familiar with the SBAR requirements and followed the SBAR format for handoffs. Thus, the investigation concluded that there was no evidence that nurses routinely fail to use the SBAR format in patient handoff communication.

Finally, the investigation found that the physician did respond to the IRRT on September 16, 2010. The physician's presence is documented by the IRRT quality assurance report completed by the Patient Care Coordinator nurse during the event, and his presence is noted in the Nursing IRRT in the medical record. However, the investigation found inadequate documentation on the event in the IRRT notes written by the Specialty Care Unit nurse and the

[2]Formerly the Joint Commission on Accreditation of Healthcare Organizations, the Joint Commission accredits and certifies more than 19,000 healthcare organizations and programs in the U.S.

nephrology nurse practitioner. The physician also failed to enter a note regarding his participation in the IRRT. Given the inadequacies discovered in the medical documentation, the OMI recommended additional training on IRRT policy to the staff involved, including training on required documentation. The report notes that documentation should be monitored for non-compliance and non-compliance should be addressed appropriately. The investigation also determined that because there was no failure to respond to the IRRT and no delay in providing critical treatment, the patient's death was not a sentinel event, and thus, no such report was required.

In January 2012, the agency confirmed that the training was completed and monthly audits of Inpatient Rapid Response Team documentation had been conducted since August. The agency reported that after the training there has been 100% compliance with documentation requirements by all services responsible for medical charting. The VA plans to continue the audits indefinitely.

I have reviewed the original disclosure and the agency report. Based on that review, I have determined that the report contains all of the information required by statute and the findings appear to be reasonable.

As required by 5 U.S.C. § 1213(e)(3), I have sent copies of the agency report to the Chairmen and Ranking Members of the Senate Committee on Veterans' Affairs and the House Committee on Veterans' Affairs. I have also filed a redacted copy of the agency report, which identifies VA employees by title only, in OSC's public file available online at www.osc.gov.[3] OSC's file on this matter is now closed.

Respectfully,

Carolyn N. Lerner

Enclosure

[3]The VA provided OSC with a report containing employee names (enclosed), and a redacted report which removes employees' names. The VA cited the Freedom of Information Act (FOIA) (5 U.S.C. § 552(b)(6)) as the basis for its redactions to the report produced in response to 5 U.S.C. § 1213, and requested that OSC post the redacted version in our public file. OSC objects to the VA's use of FOIA to remove these names because under FOIA, such withholding of information is discretionary, not mandatory, and therefore does not fit within the exceptions to disclosure under 5 U.S.C. § 1219(b).