DEPARTMENT OF VETERANS AFFAIRS
WASHINGTON DC 20420

December 12, 2014

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 No. DI-14-2754

Dear Ms. Lerner:

I am responding to your letter regarding allegations made by a whistleblower at the Phoenix Veterans Affairs (VA) Health Care System, (hereafter, the Medical Center but commonly referred to as the Hayden VA), located in Phoenix, Arizona. Dr. Katherine Mitchell (hereafter, the whistleblower), a physician board certified in internal medicine and, at the time of the site visit, the Director of the Post-Deployment Center, alleged that employees engaged 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. The Secretary has delegated to me the authority to sign the enclosed report and take any actions deemed necessary as referenced in 5 United States Code § 1213(d)(5).

The Secretary asked that the Interim Under Secretary for Health refer the whistleblower's allegations to the Office of the Medical Inspector (OMI), who coordinated a VA team that conducted a site visit to the Medical Center on September 8–11, 2014.

VA substantiated three of the whistleblower's four allegations regarding staffing shortages, inappropriate triage by nurses, and possible patient neglect, and has recommended personnel actions as appropriate. VA did not substantiate that the Medical Center lacks current nursing protocols and general policies needed to allow the nursing staff to provide appropriate patient care. VA made nine recommendations for the Medical Center: to adopt the national severity index to improve Emergency Department (ED) triage training and the number of nurses trained in it; to review certification of ED nurses; to standardize training of ED clerical staff; to improve hand-off processes in the ED; to base local policies on evidence; to base protocols on symptoms; to enforce timeliness of care; to improve accuracy of labeling; and to increase vascular laboratory staffing, where current coverage poses a risk to Veterans' health and safety.

As OSC is aware, the whistleblower who disclosed these matters (OSC File Number DI-14-2754) received expedited review of her related reprisal allegations. Some of the Medical Center leaders referenced in the retaliation allegation are the

same as those referenced in this report. Since OMI completed the attached report, the VA Office of Inspector General and the Department of Justice completed their criminal investigation at the Medical Center, enabling VA to convene an administrative board of investigation (AIB) to resolve leadership accountability issues presented in the report and in related retaliation claims. VA will be happy to provide additional information on this matter when the AIB has completed its work.

Findings from the current investigation are contained in the enclosed report, which I am submitting for your review.

Thank you for the opportunity to respond.

Sincerely,

Jose D. Riojas
Chief of Staff

Enclosure

DEPARTMENT OF VETERANS AFFAIRS
Washington, DC

Report to the
Office of Special Counsel
OSC File Number DI-14-2754

Department of Veterans Affairs
Carl T. Hayden Veterans Affairs Medical Center
Phoenix, Arizona

Report Date: November 10, 2014

TRIM 2014-D-1257

Executive Summary

The Interim Under Secretary for Health (IUSH) 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 Phoenix VA Health Care System, (hereafter, the Medical Center, but commonly referred to as the Hayden VA), located in Phoenix, Arizona. A physician, board certified in internal medicine and (at the time of the investigation) Director of the Post-Deployment Center, Dr. Katherine Mitchell (hereafter, 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, 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 September 8–11, 2014.

Specific Allegations of the Whistleblower

1. Nurses failed to conduct appropriate triage in the Hayden VAMC Emergency Department, Outpatient Ambulatory Care Clinics, and Psychiatry Clinic, resulting in harm or death to patients.
2. Hayden VAMC lacks current nursing protocols and general policies needed to allow the nursing staff to provide appropriate patient care.
3. Emergency Department employees have engaged in numerous instances of patient neglect.
4. There has been chronic short staffing in the Emergency Department, lab services, and suicide prevention teams endangering patient safety.

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 about whether the alleged event or action took place with reasonable certainty.

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

Conclusions for Allegation 1

- VA substantiates that nurses failed to conduct appropriate triage in the emergency department (ED). We have reviewed all cases identified by the whistleblower and have concerns regarding the care provided. These practices constitute a significant risk to public health and safety.

- VA substantiates that a nurse failed to conduct appropriate triage in the Psychiatry Clinic (MH) but not in the Ambulatory Care Clinics (PC).

Recommendations to the Medical Center

1. Nursing leadership adopt the national emergency severity index (ESI) training program for triage nurses; develop a plan for training them; establish performance measures for ED nurses to complete initial ESI training and annual refresher training; and conduct triage nurse peer review on an ongoing basis.

2. Nursing leadership review education and training records of ED nurses to make sure they have the training and experience required to work in the ED, in accordance with Emergency Nurses Association (ENA) guidelines.

3. Provide standardized training for the clerical staff who work in the ED to familiarize them with symptoms that require immediate nursing attention, including when to use a dedicated telephone line to contact a triage nurse rapidly.

4. Review Service Agreements to clarify policy on the seamless transition and "warm handoff" of patients between the ED and other services.[1]

Conclusion for Allegation 2

- VA did not substantiate that the Medical Center lacks current nursing protocols and general policies needed to allow the nursing staff to provide appropriate patient care. During the time the whistleblower worked in the ED, many local policies and protocols did not exist; however, the Medical Center furnished evidence that it was following national policies, and it has since established local protocols.

Recommendations to the Medical Center

5. Ensure that all nursing policies are evidence-based, up-to-date, and posted on the intranet to be readily available to staff.

6. Revise all diagnosis-based protocols to make sure they are symptom-based.

Conclusions for Allegation 3

- Because there is no documented evidence of verbal reports in the electronic health record (EHR) for Clinical Scenarios 9, 10, and 12, VA was not able to substantiate these allegations.

- Referring to clinical scenario 11, VA substantiates that nurses failed to perform EKGs when ordered, and that they failed to act upon orders for serious patient complaints such as chest pain.

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[1] A warm handoff is a standardized approach to person-to-person handoff communications that includes an opportunity to ask and respond to questions regarding the condition, and the care of, the patient.

- VA substantiates that labelling errors continue to occur in the ED due to poor adherence to policy.

Recommendations to the Medical Center

7. Establish a local performance metric for ED nurses on timeliness of procedures, e.g., EKGs and medication orders, to make sure that ED nurses adhere to standards of care.

8. Establish a local performance metric for ED staff on proper specimen labeling procedures to eliminate processing errors, and repair the label printers to prevent labels from being improperly printed.

Conclusions for Allegation 4

- VA substantiated that prior to December 2012, significant nursing and physician staffing issues existed in the ED. However, they have been resolved.

- VA substantiated that, per the Veterans Health Administration's (VHA) *Emergency Medicine Handbook,* Appendix E, page E-1, vascular technicians do not provide 24-hour services, and that the absence of this capability poses a risk to public health and safety. We are concerned that a complex facility such as the Medical Center must be able to conduct vascular ultrasound tests after hours. Currently, there is no one on-call, either in-house or under contract, to administer these tests and, if a Veteran were to have a serious medical condition, they would be unable to receive potentially life-saving diagnostics and treatment. If the Medical Center does not have the capacity to provide these services to any Veteran who may require them, it is placing all Veterans at risk.

- VA did not substantiate staffing shortages in laboratory services.

- VA substantiated that there were staffing shortages in the Suicide Prevention Team; however, these issues have been resolved, and the team is providing services in accordance with VHA policy.

Recommendation to the Medical Center

9. In conjunction with the Veterans Integrated Service Network (VISN), immediately develop and begin implementing a plan to provide 24-hour coverage of the Vascular Service by qualified vascular technicians.

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 has provided a legal review, and the Office of Accountability Review (OAR) has examined the issues from a Human Resources perspective to establish accountability, when appropriate, for improper personnel practices. VA found violations of VA and VHA policy.

With respect to accountability, the Secretary takes this very seriously. He created OAR specifically to help investigate certain matters, including whistleblower retaliation claims, in order to help reset sustained accountability within VA. As OSC is aware, the individual who disclosed these matters (OSC File Number DI-14-2754) received expedited review of the related whistleblower reprisal allegations. Some of the Phoenix VA Medical Center leaders referenced in the retaliation claims are the same as those referenced in this report. Until the VA Office of Inspector General (OIG) and Department of Justice (DOJ) complete their ongoing criminal investigation at this facility, VA is unable to interview Phoenix VA Medical Center (VAMC) leaders regarding the charges present in this report or the related retaliation claims. VA plans to review the results of the ongoing criminal investigation and to then complete its own administrative investigation to ensure that it has all relevant evidence before accountability actions are completed. VA will be happy to provide additional information on this matter as soon as it becomes available.

Table of Contents

I. Introduction

The IUSH requested that OMI assemble and lead a Department of Veterans Affairs (VA) team to investigate allegations lodged with the OSC concerning the Medical Center. The whistleblower alleged that employees engaged 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. A VA team conducted a site visit to the Medical Center on September 8–11, 2014.

II. Facility Profile

The Medical Center, part of VISN 18, is a complexity level 1c tertiary care facility with six community based outpatient clinics (CBOC) in Phoenix, Mesa, Payson, Show Low, Globe, and Surprise, Arizona.[2] The Medical Center is a teaching hospital, providing a full range of patient care services, with state-of-the-art technology and research. Comprehensive health care is provided through primary care, long-term care, and tertiary care in the areas of medicine, surgery, psychiatry, physical medicine and rehabilitation, neurology, oncology, dentistry, nutrition, geriatrics, and extended care. Comprised of 177 inpatient beds and 104 community living center beds, the Medical Center maintained an average daily census of 163, with 779,197 outpatient visits and 3,827 surgical procedures in fiscal year (FY) 2013.

The Medical Center has 464 affiliation agreements with more than 145 institutions and supports and funds over 80 resident positions annually. It has fully integrated training programs with Banner Good Samaritan (family medicine, general surgery, oral maxillofacial surgery, internal medicine, obstetrics and gynecology, orthopedics, psychiatry, cardiology, endocrinology, gastroenterology, geriatrics, and pulmonary/critical care medicine), Maricopa Integrated Health System (psychiatry and radiology), and the Mayo School of Graduate Medical Education (dermatology, otolaryngology, and gastroenterology). The Medical Center also has an active affiliation with the University of Arizona College of Medicine-Phoenix and is involved in the educational programs of A.T. Still University and Midwestern College of Osteopathic Medicine. It has nursing affiliations with Arizona State University, University of Phoenix, Grand Canyon University, Chamberlain College, Northland Pioneer College, and the Maricopa Community Colleges.

III. Specific Allegations of the Whistleblower

1. Nurses failed to conduct appropriate triage in the Hayden VAMC Emergency Department, Outpatient Ambulatory Care Clinics, and Psychiatry Clinic, resulting in harm or death to patients;

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[2] Complexity level 1c: 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 is the least complex; complexity for level 2 facilities is considered moderate. (VHA Executive Decision Memo (EDM), *2011 Facility Complexity Level Model*).

2. Hayden VAMC lacks current nursing protocols and general policies needed to allow the nursing staff to provide appropriate patient care;
3. Emergency Department employees have engaged in numerous instances of patient neglect;
4. There has been chronic short staffing in the Emergency Department, lab services, and suicide prevention teams endangering patient safety.

IV. Conduct of Investigation

The VA team conducting the investigation consisted of [redacted], MD, Medical Investigator (an internist); [redacted], Nurse Practitioner (NP), Clinical Program Manager; [redacted], Registered Nurse (RN), MSN, VHA-CM, (former Chair of the ED Advisory Work Group for the Office of Nursing Services); [redacted], MD (an emergency medicine physician); and [redacted], Human Resources (HR) Specialist, (VA Secretary's Office of Accountability Review). VA reviewed relevant policies, procedures, professional standards, reports, memorandums, and other documents listed in Attachment A. We toured the Medical Center's ED, Outpatient Ambulatory Clinics, and Psychiatry Clinic area, and held entrance and exit briefings with Medical Center leadership.

VA initially interviewed the whistleblower via teleconference on September 2, 2014, and [redacted], MD, the Medical Center's former Chief of Staff (CoS), via teleconference on September 4, 2014. We conducted a second interview at the Medical Center with the whistleblower on September 9, 2014. We also interviewed the following Medical Center employees:

- [redacted], MD, Deputy CoS
- [redacted], RN, (ED Nurse Manager (NM))
- [redacted], MD (ED Director)
- [redacted], MD, [redacted], DO, [redacted], MD, and [redacted], MD (ED physicians)
- [redacted] (ED physician assistant (PA))
- [redacted] and [redacted] (administrative staff)
- [redacted] (former ED NM)
- [redacted], MD, Chief, Pathology and Laboratory Medicine Services (P&LMS)
- [redacted] (Manager, P&LMS)
- [redacted] and [redacted], (P&LMS technicians)
- [redacted], HR
- [redacted] (Acting Chief Nurse Executive and Office of Nursing Services Director, Workforce and Leadership)
- [redacted], [redacted], and former member [redacted], Suicide Prevention Team
- [redacted], MD, Chief, Vascular Services
- [redacted] vascular technician
- [redacted], MD, MPH, former Chief, Primary Care (PC)

- [redacted], Administrative Officer (AO), PC
- [redacted], former Nurse Executive, PC
- [redacted], DO, Chief, Psychiatry Clinic
- [redacted], DO, (Psychiatrist); and Kathleen Gale, (NM)
- [redacted], Chief, Nursing Education
- [redacted] (VISN Deputy Quality Management (QM)
- [redacted] (former Lean Systems Redesign Facilitator)
- [redacted], Chief, Quality, Safety and Improvement (QSI)

At the VISN, we interviewed [redacted] (Workforce Development Program Manager) and [redacted] (former Medical Center Patient Safety Officer (PSO) who now practices patient care). The Medical Center's CoS, [redacted], DO, was interviewed via teleconference on September 22, 2014.

VI. Findings, Conclusions, and Recommendations

Emergency Department 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.

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, and to counter this, some EDs refer patients with very minor problems for treatment at clinics or to their own physicians.[3]

In accordance with VHA *Emergency Medicine Handbook* (VHA Handbook 1101.05), which states that RNs are to triage according to the Emergency Nurses Association (ENA) position statement on triage qualifications (July 1996), nurses must use this as the sole triage tool. The ESI 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.[4] The highest level of acuity, 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

[3] 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.
[4] VHA Handbook 1101.5, Emergency Medicine, May 12, 2010.

patient's vital signs (e.g., blood pressure, respiratory rate, or heart 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 (PAs and NPs) typically care for them in the ED setting.[5]

General nursing education does not adequately prepare the ED nurse for the complexities of the 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.

Allegation 1

Nurses failed to conduct appropriate triage in the Hayden VAMC Emergency Department, Outpatient Ambulatory Care Clinics, and Psychiatry Clinic, resulting in harm or death to patients.

Findings

A. ED Triage Processes at the Phoenix VAMC

Upon presenting to the Medical Center's ED, Veterans are initially seen by a clerical worker who determines whether they had been seen previously at the facility. After verifying the Veteran's eligibility, the clerical worker registers them and then passes them on to an RN. This process has been in practice since 2009. Previously seen Veterans are registered and proceed to triage. Veterans new to the Medical Center are referred to the enrollment area where their eligibility is determined and they are enrolled in the facility; then, they are transferred to triage. Clerical workers have no formal medical training, do not take the patient's vital signs, nor do they perform any medical assessment. They do have some rudimentary knowledge of illness conditions. Although none of the clerical workers interviewed were able to produce written guidance, all stated that those patients who appeared to be too ill for eligibility determination could be referred directly to the triage nurse for an initial medical assessment. However, this decision was left to the judgment of the clerical worker. When necessary, the clerical staff may use a dedicated telephone that dials directly to the triage area to expedite treatment in cases of severe emergency, or if a patient experiences a change in status while in the waiting area. In the event of an emergency or life-threatening situation, the clerks have been authorized to complete a limited registration on the spot. If the patient is admitted, administrative staff complete the full registration later at the bedside.

[5] 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

Both the American College of Emergency Physicians and the Joint Commission recommend that emergency patients should be seen initially by a triage nurse and/or taken directly to a treatment room if an examination area is available, as patients may not know whether their symptoms represent an emergent or urgent condition. If, as a result of a VA health care screening, a staff member determines that the patient is in need of emergency care, a physician must examine the patient promptly and furnish the necessary care. The determination of eligibility for benefits for patients with emergent conditions can be made after the initial examination and essential treatment. Depending upon the patient's medical condition, the examining physician determines whether an administrative interview is appropriate and to what extent the clerical worker can question the patient.

RNs complete all triage duties in the Medical Center ED. An ED Systems Redesign project conducted in FY 2010–2011 recommended the creation of triage protocols and training RNs to understand them. In January 2012, the Nurse Executive approved attendance at a conference sponsored by Triage First, experts in triage training, to teach five ED nurses the triage process.[6] Although these nurses attended the training, the Medical Center had no "train the trainer" program to allow them to share their knowledge with the rest of the RN staff. None of the five RNs remain on the staff.

Despite the availability of a free, nationally recognized curriculum developed by the Agency for Healthcare, Research, and Quality (ARHQ), the Medical Center is using a locally developed Talent Management System (TMS) module to train ED nurses in triage skills. VA compared the contents of the Medical Center's program to the ARHQ's and identified many gaps in the locally-developed course that omit critical education content. We found no evidence of an established length of time for nurses to obtain triage education and skills, nor did we find a time requirement for "on-the job training and classroom work," before they are assigned triage duties.

VA reviewed the training records of 31 ED nurses and found that as of September 5, 2014, only 11 had completed the TMS module. We also randomly audited five patient records and found that they had been triaged by nurses who had not completed the module. On that date, neither the charge nurse for the day, the NM, nor the Assistant NM had completed the module. Staff members at all levels reported that before 2012, only one nurse at a time would triage ED patients. Since that time, all ED nurses perform triage duties and, on any given day, two nurses at a time perform triage. One ED nurse reported that she frequently sees patients in the waiting room when they should have been attended to. The waiting room is difficult to see from the triage area. Patients treated in the continuing care room, next to the triage room, are easy to observe. This room is used for patients who do not need cardiac monitoring, are awaiting other treatments, or awaiting test results for their discharge.

[6] Triage First is a company specializing in emergency department triage education and implementation for process improvement. Triage First has trained over 22,000 nurses nationally and internationally since 1996, and currently has over 25 triage educators nationwide. http://www.triagefirst.com/

In our audit of the five ED charts, we also assessed the appropriateness of ESI assignments and patient treatment. In all five cases, the patients were improperly triaged, having been assigned a lower severity level than appropriate. However, from all indications, these patients received appropriate medical care.

Of the 22 beds in the ED, only 8 have cardiac monitoring capability. Because triage is constant, patients are moved in and around the ED as their need for a monitored bed changes. At times, the need for a monitored bed exceeds the ED's capacity to provide it.

Clinical Care

During both interviews with the whistleblower, we attempted to ascertain the identities of the Veterans cited in the 13 clinical scenarios referenced in OSC's letter. The whistleblower was able to identify the Veterans involved in 8 of them (scenarios 2, 3, 4, 7, 9, 10, 11, and 12). In some scenarios, the same patients were involved, e.g., scenarios 3 and 4 related to the same Veteran. The whistleblower was unable to identify the patients involved in scenarios 1, 5, 6, 8, and 13; therefore, VA can provide no further information on these cases. The scenarios addressed here are presented in the same order in which they were described in the OSC referral letter.

Within the Medical Center, all employees are permitted to bring their quality of care concerns to the attention of the Risk Management Office (RMO). All cases reported to the RMO are reviewed in accordance with VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*. Issues requiring additional investigation are completed in accordance with VA Directive 0700, *Administrative Investigations*, March 25, 2002. In the OSC letter, the whistleblower said she learned from employees in the RMO that they had been directed by the former CoS and the former Nurse Executive not to investigate cases she submitted. VA's interviews with both the former RM and the former PSO revealed that they had reviewed cases brought forward by the whistleblower. The PSO stated that while the whistleblower did bring a number of cases to the office, she also brought employee information, including their background education, complaining that the employees were not qualified to be in the ED, thereby putting patients at risk. According to the PSO, the whistleblower's complaints centered on nursing practices, not patient outcomes, because in none of the cases brought to her attention had patients experienced bad outcomes.

The former RM said she reviewed clinical cases in consultation with the former CoS, including those brought to her attention by the whistleblower. Both the physician and nursing Peer Review Committees (PRC) routinely completed peer reviews as appropriate. Under direct questioning, the former RM said that she was never told not to review the whistleblower's cases by anyone. The current CoS, who assumed his role in February 2012, said he did not prevent the whistleblower from bringing cases forward. He also confirmed the former RM's statement that all cases had been reviewed and sent to their respective PRCs. His opinion was that the whistleblower was expecting nursing staff to initiate care that required a physician's orders. He also said

that she expected nurses to assess complications of the disease process, despite the fact that this was a physician responsibility.

The whistleblower sent additional documents to VA on September 2, 2014, and an email on September 14, 2014, in which she cited another 33 records for us to review. We reviewed 11 of the 33 records – those patients whom the whistleblower could identify – examining the nursing notes, ancillary notes, laboratory values, radiology reports, and physician notes for each patient.

The whistleblower repeatedly refers to nursing personnel failing to inform the physician when placing patients in rooms, and neglecting to provide nursing reports to the physician promptly. VA observed that patient movement was displayed on the ED Information System throughout the department, and that all members of the care team had access to this information. Because there are no written records in the EHR of verbal reports, there is no evidence available to either prove or disprove the whistleblower's statement that nurses did not provide verbal reports.

Clinical Scenarios for Allegation 1: Nurses failed to conduct appropriate triage in ED

Clinical Scenario 2
A 64-year-old patient with low blood pressure and tachycardia who reported having "difficulty with ambulation, weakness, and no energy" was assigned an Emergency Severity Index 3 and waited over 10 hours in the ED waiting room.

On March 31, 2012, this Veteran with a history of metastatic cancer of the tonsils and a cerebrovascular accident (CVA, commonly known as a stroke), was triaged in the ED. Upon presentation, his heart rate was elevated to 130, and his blood pressure (BP) was in the low normal range at 97/70. The Veteran's chief complaint was an inability to eat, weight loss, and lack of energy. The triage was completed at 12:47 p.m. At 6:30 p.m., before being transferred to an ED examination room, an RN placed an IV line for the administration of fluids. At 7:00 p.m., the Veteran's vital signs were repeated. His heart rate was normal at 82; however, the BP was low at 88/59. Following a complete assessment by the whistleblower, the Veteran was admitted to the Medical Center for dehydration. Our review of this case raises concerns about the initial ESI level assigned, although he did not suffer harm as a result.

Clinical Scenarios 3 and 4
A 74-year-old patient was deemed stable for the waiting room despite documented severe abdominal pain, nausea, vomiting, and tachycardia, waiting over four hours before receiving care. This patient, who was on warfarin, was experiencing significant lethargy, dizziness, and increasing confusion, was documented as stable and sent to the lobby. Subsequent ED testing indicated the patient was at an extremely high risk for spontaneous bleeding within the brain.

On May 2, 2012, at 1:58 p.m., an RN triaged this Veteran with dementia, alcohol misuse, and a history of recurrent pulmonary emboli, requiring chronic anticoagulation with warfarin.[7] The primary concerns presented by his family were that he was becoming more confused, had been taking more than the prescribed amount of medication (including warfarin), was unstable on his feet, and unable to care for himself without assistance. The family stated that they were unable to provide the care that he needed. Upon arrival, this Veteran's vital signs were normal. The nurse assigned an ESI level of 3 and placed him in the ED waiting room.

At 9:35 p.m., an RN placed the Veteran in an ED examination room. The family reported that he had become more confused and disoriented while in the waiting room. At 9.55 p.m., the RN drew blood for the completion of several tests, including an international normalized ratio (INR). At 10:30 p.m., a computerized tomography of the head was completed, revealing "no acute intracranial abnormality." At 12:27 a.m., the whistleblower was notified that the Veteran's INR was supratherapeutic at a value "greater than 24.1," which is a critically high level – the generally accepted range is 2 to 3. The Veteran was admitted to the Medical Center for pharmacological correction of the supratherapeutic INR. Our review of this case raises concerns about the initial triage level assigned and placing this Veteran in the waiting room for an extended period of time.

B. Outpatient Ambulatory Care Clinics (ACC) and Psychiatry Clinic (MH) Triage

The whistleblower said she observed deficiencies in the triage process in both the ACC and MH because these nurses received ESI triage training. The ESI tool is designed exclusively for the ED, and is not appropriate or relevant to the type of care that these clinics provide. However, VA learned that ACC utilizes both the Briggs telephone triage manual and the Patient Aligned Care Teams (PACT) roles and responsibilities protocols for triage guidance; these are different from the ESI tool. For triaging its patients, the MH uses the Patient Assessment policy (Medical Center Memorandum No. COS/11-70, December 27, 2011), as well as a risk assessment. While ESI training is not mandatory for staff in any of these clinics, it would be a valuable tool for them to have in the event of a mass casualty situation.

Clinical Scenarios for Allegation 1: Nurses failed to conduct appropriate triage in Outpatient Ambulatory Care Clinics and Psychiatry Clinic

Clinical Scenario 7
In 2013, a nurse inappropriately triaged an inebriated patient with hypotension and resting tachycardia, failed to notify ED physicians about the patient for four

[7] Warfarin is an anticoagulant used in the prevention of thrombosis and thromboembolism, the formation of blood clots in the blood vessels and their migration elsewhere in the body, respectively. Despite its effectiveness, treatment with warfarin has several shortcomings. Many commonly used medications interact with warfarin, as do some foods such as leafy green vegetables since these typically contain large amounts of vitamin K, which counteracts the effects of warfarin. Its activity has to be monitored by blood testing for the INR to ensure an adequate yet safe dose is taken. A high INR predisposes to a high risk of bleeding, while an INR below the therapeutic target indicates the dose of warfarin is insufficient to protect against thromboembolic events.

hours, and then failed to appropriately enter patient data into the ED information system.[8]

The whistleblower said that she did not retain this Veteran's identification. She described the case above, and added that this MH clinic Veteran's care was delayed due to the lack of communication between nurses in MH and the ED. As a matter of routine, MH nurses conduct retrospective chart audits and forward them to the NM, who reviews them for accuracy and determines whether they need to be forwarded to the PRC. The NM said that they use suicide risk assessments on all patients reporting to MH. The NM also said that there had been a problem with this Veteran's triage and that the nurse who assessed this Veteran had been pulled out of triage, reeducated on the clinic's process, and returned to the triage team, all of which was done in conjunction with the union. The NM had reviewed the above case and believed that the RN at that time should have consulted with a provider, especially on the issue of weapons since the Veteran was carrying a gun.

VA's further review of the case indicated that the Medical Center had taken steps to improve clinical dialog and cooperation between ACC and MH, which has led to service agreements describing the processes for same-day psychiatry evaluations and for facilitating the graduation of stable MH patients back to their ACC providers. These agreements, established on June 1, 2011, also created a referral process between the ED and MH. Within the framework of these service agreements, ACC and MH have developed a more formalized flow process, but both appear to lack transfer policies to the ED.

Conclusions for Allegation 1

- VA **substantiates** that nurses failed to conduct appropriate triage in the ED. We have reviewed all cases identified by the whistleblower and have concerns regarding the care provided. These practices constitute a significant risk to public health and safety.
- The clerks are not properly trained to manage patients in the ED.
- VA **substantiates** that a nurse failed to conduct appropriate triage in MH, but not in ACC.

Recommendations to the Medical Center

1. Nursing leadership adopt the national ESI training program for triage Nurses; develop a plan for training them; establish performance measures for ED nurses to complete initial ESI training and annual refresher training; and conduct triage nurse peer review on an ongoing basis.

[8] The whistleblower acknowledged that the OSC letter incorrectly listed the date as June 6, 2012. This occurred in 2013.

2. Nursing leadership review education and training records of ED nurses to make sure they have the training and experience required to work in the ED, in accordance with ENA guidelines.

3. Provide standardized training for the clerical staff who work in the ED to familiarize them with symptoms that require immediate nursing attention, including when to use the dedicated telephone line.

4. Review Service Agreements to clarify policy on the seamless transition and "warm handoff" of patients between the ED and other services.

Allegation 2

Hayden VAMC lacks current nursing protocols and general policies needed to allow the nursing staff to provide appropriate patient care.

Findings

In 2011, the ED Lean Systems Redesign team made recommendations to improve the ED. It identified the need to develop comprehensive triage protocols. The whistleblower was responsible for this task. The former NM of the ED was aware of the Lean Systems Redesign recommendations and had tried to have meetings with the whistleblower. She said it was difficult to coordinate meetings, because the NM worked days and the whistleblower worked nights. In October 2011, the NM transferred out of the ED. In 2012, the whistleblower exchanged emails with the Nurse Executive and the new NM of the ED in reference to the protocols. Although the whistleblower had made some changes to the Medical Center's triage protocols for ED RNs, these new protocols were not implemented until several months after the whistleblower had left the ED. The protocols currently used in the ED went online in December 2013, after approval by the ED physicians and RN staff. All interviewees asserted that the ED continued to follow national guidelines for ED practice as described in VHA Handbook 1101.05.

Prior to adoption of the protocols, the nurses in the ED had used *Mosby's Nursing Consult* online.[9] The NM said the nurses are not allowed to order any laboratory tests or initiate treatments, but in the event that a patient needs life-sustaining measures, they are allowed to initiate nursing interventions.[10] The whistleblower also alleged that nurses would not initiate protocol order entries for serious complaints. All ED RNs and nursing leaders told VA that they were not going to work outside the scope of their

[9] *Mosby's Nursing Consult* permits nurses to quickly find evidence-based answers to clinical questions at the bedside, educate patients, improve the quality of care, and stay informed of new developments in nursing. http://www.nursingconsult.com/nursing/index

[10] A nursing intervention is any act by a nurse in the delivery of care, such as turning a comatose patient to avoid the development of decubitus ulcers or teaching insulin injection technique to a patient with diabetes before discharge. *Mosby's Medical Dictionary*, 8th edition. © 2009, Elsevier. http://medical-dictionary.thefreedictionary.com/nursing+intervention

licensure. In true emergency situations, they would proceed with nursing interventions, such as completing EKGs for patients with chest pain.

The Risk Management reviewers of the cases presented by the whistleblower concluded that her complaints were based on expectations of nurses initiating orders, which would exceed their scope of practice. The Chief, QSI, noted that since protocols have been approved, a physician must enter an order before nurses can follow the protocol. For example, when a patient is being evaluated for abdominal pain, a physician must write an order authorizing the nursing staff to initiate care according to the abdominal pain protocol.

VA reviewed the protocols in place at the Medical Center and identified 24 protocol order sets. A few examples of available protocols are: abdominal pain, acute stroke, cardiac event, and liver failure. While abdominal pain refers to a symptom, the remaining three protocols presume the diagnosis. Nurses are unable to make diagnoses. Nurses do not diagnose but rather collect sufficient data related to the presenting problem and medical history, recognize and match symptom patterns to those in the protocol, and assign acuity to the patients. The common, accepted practice with triage protocols is to create symptom-based algorithms that provide a series of actions (which may include a number of medications) to be implemented to manage a patient's clinical status. The nurse decides which specific interventions to apply, based on the patient's meeting criteria outlined in the protocol, from the listed interventions within the nurse's scope of practice. The protocol may also include alternative actions or "exceptions" to the prescriptive orders, allowing for individual patient circumstance as assessed by the nurse.

Conclusion for Allegation 2

- VA **did not substantiate** that the Medical Center lacks current nursing protocols and general policies needed to allow the nursing staff to provide appropriate patient care. During the time the whistleblower worked in the ED, many local policies and protocols did not exist; however, the Medical Center furnished evidence that it was following national policies, and it has now established local protocols.

Recommendations for the Medical Center:

5. Ensure that all nursing policies are evidence-based, up-to-date, and posted on the intranet to be readily available to staff.

6. Revise all diagnosis-based protocols to make sure they are symptom-based.

Allegation 3

Emergency Department employees have engaged in numerous instances of patient neglect. The whistleblower also alleged that ED nurses were drawing blood at the bedside, but labeling the specimens in a common area.

Findings

Clinical Scenarios related to Allegation 3: ED employees engaging in patient neglect.

Clinical Scenario 9

On June 21, 2012, a nurse placed an unattended patient with tachycardia in a room without informing a physician for almost 3 hours.

According to the EHR, the patient, a 69-year-old female Veteran with a history of hypertension, checked into the ED at 8:42 p.m. The initial vital signs, completed at 8:44 p.m., included a pulse of 112 and BP of 167/88. She was assigned an ESI level 3. Although the whistleblower alleges that the patient was placed in a room for 3 hours without a physician being informed, the nurse documented that the whistleblower was in the room with the patient at 9:20 p.m. The whistleblower entered multiple nursing, laboratory, and medication orders at 9:25 p.m. and initiated her progress note at 9:29 p.m. The Veteran, diagnosed with dehydration, received IV fluids in the ED and was discharged to home within 3 hours of her check-in time. The evidence contained in the EHR does not support the allegation.

Clinical Scenario 10

On July 27, 2012, a nurse failed to deliver a verbal report and EKG to the whistleblower on a patient admitted for chest pains and a history of myocardial infarction. The whistleblower discovered this after the patient had been left unattended for over an hour.

On June 27, at 7:31 p.m., this patient, a 53-year-old Veteran who had suffered a myocardial infarction at age 45, checked into the ED with chest pain after taking two nitroglycerin tablets. He was triaged as an ESI level 2. The nurse completed triage vital signs at 7:45 p.m. The whistleblower initiated her progress note at 7:49 p.m. and entered multiple nursing, laboratory, and medication orders at 8:05 p.m. The nurse placed the Veteran on a cardiac monitor, obtained an EKG, and completed orthostatic vital signs at 8:30 p.m. The evidence in the EHR does not support the whistleblower's allegation regarding this Veteran.

Clinical Scenario 11

On October 9, 2012, nursing staff misplaced medication orders for a patient with a recent, documented heart attack, who presented in the ED with severe chest pain.[11] Consequently, there was a delay of longer than an hour in giving the patient aspirin and nitroglycerin as ordered by a physician.

The Veteran, a 64-year-old male with a recent heart attack, presented to the ED on October 9, 2012, at 4:09 p.m. with chest pain. The triage nurse assigned an ESI level of 2, but did not immediately place this Veteran in an examination room because no monitored beds were available. At 4:16 p.m., the whistleblower wrote orders for an

[11] The date documented in the OSC letter is incorrect, and is October 9, 2012, as documented above.

EKG, IV line, and continuous cardiac monitoring, along with several laboratory tests. At 4:24 p.m., the nurse documented the first set of vital signs in the EHR. At 4:25 p.m., both the nurse and the whistleblower initiated progress notes in the EHR. At 4:38 p.m., the whistleblower placed a second set of orders for an EKG, IV line, and continuous cardiac monitoring because they had not been done. At 4:39 p.m., she wrote several medication orders including sublingual nitroglycerine and aspirin. The nurse completed an EKG and placed the Veteran in an examination room on a cardiac monitor at 5:00 p.m. At 5:15 p.m., the nurse started the Veteran's IV line. At 6:00 p.m., the nurse gave the Veteran a dose of nitroglycerine, resulting in resolution of his symptoms within 5 minutes. At 8:29 p.m., the whistleblower admitted the Veteran to the hospital for acute coronary syndrome.

The standard of care, according to the joint guidelines of the American College of Cardiology and the American Heart Association, is that an EKG should be obtained within 10 minutes of arrival. The PRC did not confirm the allegation that there were misplaced medication orders because the EHR clearly documents all orders entered by physicians. However, VA is concerned about the timeliness of the care provided in this case.

Clinical Scenario 12
On October 18, 2012, nurses placed a suicidal patient in a room unattended and did not inform physicians about the patient for almost an hour.

The Veteran, a 54-year-old male with suicidal ideation, was triaged as an ESI level 2. Evidence in the EHR does not support the whistleblower's allegation, as it documents that a social worker was in the room with the patient within 5 minutes of the triage vital signs, and the "one-to-one" order, under which a staff member personally monitors the patient at all times, was discontinued by the whistleblower herself within 5 minutes of her evaluating the patient.

The whistleblower indicated, "in June 2011, a patient experienced a significant abnormal heart rhythm, which the floating nurse did not detect. The patient went into cardiac arrest and required resuscitation by a physician." However, because she was not able to provide patient identifiers, VA was unable to investigate this case.

The Collection of Blood Specimens

In order to minimize errors during blood specimen collection, clinical staff members must adhere to nationally-accepted guidelines. The American Society for Clinical Pathology estimates that more than 1 billion venipunctures are performed annually in the United States. In order to prevent labeling errors, blood specimens must be labeled at the bedside after comparing the information on the label with the patient's identification bracelet.

During our investigation, P&LMS staff told VA about sporadic problems with specimen labeling. We reviewed an email from the Chief, PC, indicating that an employee in

P&LMS was exposed to contaminated blood products when emptying a biohazard bag. This email implied that there was or could have been a mix up in blood samples, due to the fact the second sample of three drawn from that employee tested positive for Hepatitis B. The first and third samples were negative. VA received no patient identifiers to evaluate this occurrence.

VA reviewed the Root Cause Analysis (RCA) on the mislabeling of blood drawn in the ED on March 31, 2014.[12] The RCA revealed that the printer does not print a blank label between patients as it is supposed to, so it is possible to mistake one patient's laboratory test label for another. The RCA also found that staff do not always follow Medical Center procedures; they continue to label laboratory specimens away from the bedside where they cannot compare the label directly with the armband of the Veteran, as policy requires (Medical Center policy, *Collecting the Blood Sample*, November 21, 2013). VA learned that the Medical Center has been monitoring and correcting a few instances of labelling error. The RCA indicated there is a staff perception that if an error is made in patient identification, no consequences will occur for those involved. As a result of our investigation, on September 11, 2014, the NM of the ED began monitoring the labeling of laboratory specimens and publishing the names of staff members who are not compliant with the policy for other ED staff to see. Medical Center leadership stated that noncompliance with this policy will be reflected in the ED staff's annual evaluation. Between January 2014 and June 2014, the error rate for labelling specimens ranged from 0.01 to 0.14 per 1000 labels, whereas the national average is 0.10 and the desired standard is less than 0.22.

Conclusions for Allegation 3

- Because there is no documentary evidence of verbal reports in the EHR for Clinical Scenarios 9, 10, and 12, VA **was not able to substantiate** these allegations.

- Referring to clinical scenario 11, VA **substantiates** that nurses failed to perform EKGs when ordered, and that they failed to act upon orders for serious patient complaints such as chest pain.

- VA **substantiates** that labelling errors continue to occur in the ED due to poor adherence to policy. However, labelling error rates are less than the national average and the standard.

[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

Recommendations to the Medical Center

7. Establish a local performance metric for ED nurses on timeliness of procedures, e.g., EKGs and medication orders, to make sure that ED nurses adhere to standards of care.

8. Establish a local performance metric for ED staff on proper specimen labeling procedures to eliminate processing errors, and repair the label printers to prevent labels from being improperly printed.

Allegation 4

There has been chronic short staffing in the Emergency Department, lab services, and suicide prevention teams endangering patient safety.

During the whistleblower's tenure, from 2009 to 2012, as Co-Director or Director of the ED, the number of visits increased from fewer than 6,000 visits per year to more than 30,000. This increase in demand for services stretched the capacity of the department's staff of 24 nurses and 7 physicians.

Calendar Year	ED Visits
2011	23,524
2012	30,312
2013	31,579
2014 Projection	34,321

Nursing Staffing

With an increased demand for services came an increased demand for staff. In FY 2011, the ED Lean Systems Redesign Team recommended the prompt filling of nursing vacancies. In FY 2011, Medical Center leadership increased ED full-time equivalent employees (FTEE) by three. Later, an additional four FTEEs were authorized. At that time, nursing leadership also worked with the union to provide for better 24-hour coverage though staggered shifts.

In FY 2012, ED RN FTEE increased from 24 to 31, and by 2013, 3 more were added to the nursing staff to bring it up to the current level of 34 RNs, 1 licensed practical nurse (LPN), and 13 nursing assistants (NA). Currently, all nursing positions are filled with the exception of 4 NA vacancies.

Fiscal Year	RNs		LPNs		NAs	
	Authorized	Actual	Authorized	Actual	Authorized	Actual
2008	25	25.5	0	0	4	2
2009	25	29	0	0	4	6
2010	24	24	0	0	6	5
2011	24	24	0	0	6	6
2012	31	22	0	0	6	7
2013	34	24	1	1	13	5
2014	34	35	1	1	13	9

With the shortage of ED nursing staff, nursing supervisors from other departments assigned their staff to provide cross coverage for the ED. Currently, all newly hired nursing staff members are trauma or ED trained. The ED NM has hired nurses with more experience and education in emergency care. An additional nurse came on board October 6, 2014. All RNs have Advanced Cardiac Life Support (ACLS);[13] more than 58 percent have Pediatric Advanced Life Support (PALS);[14] and 56 percent have specialty certifications, such as Certified Emergency Nurse, Trauma Nurse Specialist, Advanced Trauma Life Support, and Sexual Assault Nurse Examiner.[15] One nurse has a Doctorate degree; 8 have Masters degrees; and 21 have Bachelors of Science in Nursing degrees. Nurses floated to the ED have an orientation prior to coming to the ED and are only assigned ESI level 4s and 5s. The ED does not float nurses to other departments.

Long Hours of Duty

The Deputy CoS witnessed a meeting between the CoS and the whistleblower to discuss nursing triage. She did not address physician staffing during any meetings. The Deputy CoS stated that during this time, the ED was heavily reliant on contract

[13] ACLS is designed for healthcare professionals who either direct or participate in the management of cardiopulmonary arrest and other cardiovascular emergencies. This includes personnel in emergency response, emergency medicine, intensive care, and critical care units. http://www.heart.org/HEARTORG/CPRAndECC/HealthcareProviders/AdvancedCardiovascularLifeSupportACLS/Advanced-Cardiovascular-Life-Support---Classroom_UCM_306643_Article.jsp

[14] The PALS Course is for health care providers who respond to emergencies in infants and children. These include personnel in emergency response, emergency medicine, intensive care and critical care units such as physicians, nurses, paramedics and others who need a PALS course completion card for job or other requirements. http://www.heart.org/HEARTORG/CPRAndECC/HealthcareProviders/Pediatrics/Pediatric-Advanced-Life-Support-PALS_UCM_303705_Article.jsp

[15] Certification is a process by which a nongovernmental agency validates, based upon predetermined standards, an individual's qualifications for practice in a defined functional or clinical area of nursing. http://www.aacn.org/wd/certifications/content/consumer-whatiscert.pcms?menu=certification

physicians due to shortages in Medical Center staff. The whistleblower told VA that she used to routinely work more than a 40-hour work week; she stated in the OSC letter, "at one point [I] was compelled to work 19 days in a row to cover open shifts and short staffing, which is in violation of VA policy." She informed us that during a meeting with the HR Manager she was told that VA's policy, *Hours of Duty and Leave* (VA Handbook 5011, April 15, 2002), contained a "24/7" requirement providing the authority to have a physician work long hours. VA reviewed the whistleblower's timecards for the 19 days, covering two pay periods, and validated that she had indeed worked more than 40 hours.

The HR Manager stated that she never met with the whistleblower or had any discussion with her regarding working long hours. According to this individual, the *Hours of Duty and Leave* policy simply meant that a physician would be available 24/7, and not that he or she would be expected to work long periods of time.

The whistleblower said that all physician and nurse vacancies in the ED had to be announced in the same fashion as normal Competitive Service positions; she was concerned that such a requirement adds significantly to the time it takes to fill positions there. Though no such announcements were provided to support this claim, the HR Manager informed VA that no such requirement exists: physicians and nurses are in the Excepted Service category, exempting them from the customary hiring requirements that pertain to the Competitive Service.

The current CoS stated he had never required the whistleblower to work long tours of duty or multiple consecutive shifts. During the time that she worked long hours and multiple consecutive shifts, the whistleblower was the supervisor who scheduled her own time and who had overall responsibility for the ED physician schedule. The current CoS stated that the whistleblower scheduled herself to cover open time periods, rather than scheduling someone else. In reviewing the schedules, VA found that the whistleblower was the default person for open shifts, mostly at night. The remaining physicians worked their regularly scheduled tours, taking normal leave and days off when requested.

In June 2012, the AO was charged with taking over scheduling for the ED. He said that the schedule was chaotic and that fee-based providers often appeared for work when they had not been scheduled, or failed to show up when they were. He went on to say that he put an end to this practice by assigning the fee-based providers to specific times for a more complete and robust schedule.

Leadership realigned the ED from the Primary Care Department to the Medicine Department in November 2012, and the following month appointed the present Director of the ED, a staff physician certified in Emergency Medicine. After assessing the schedule, the new ED Director sent emails requesting coverage from both permanent staff in the department and other areas of the Medical Center, as well as to fee-based providers. If these providers worked in other departments prior to working in the ED,

their credentials were reviewed and privileges for work in the ED were requested and approved prior to their providing service there.

After a temporary goal of increasing fee-based providers to flesh out ED staffing was met, the Director sought a more permanent solution by requesting the hiring of seven permanent ED physicians. This has decreased the dependence on fee-based providers as well as saved the Medical Center money.

When the current Director came on board, the ED had nine provider positions including his own and that of a PA. Medical Center leadership authorized five additional physicians in December 2012, and six more in October 2013, along with another PA. Currently, 11 of the 19 physicians on staff are board certified in Emergency Medicine. The Medical Center now has 19 FTEEs for physicians and 2 FTEEs for PAs. The physicians serve staggered shifts throughout the 24-hour day, with a minimum of two physicians on shift at night. ED staff told us that increases in both nurse and physician staffing has brought about enhanced communication between staff members and improved morale.

Lack of an on-call vascular lab tech and ultrasound services

VHA's *Emergency Medicine Handbook* Appendix E, page E-1, states that Doppler[16] studies are "to be readily available 24 hours a day for emergency patients." Several sources at the Medical Center confirmed that vascular duplex ultrasound was available on weekday tours until 8:00 p.m., for 6 hours or less on Saturdays, and not at all on Sundays. The weekend coverage is provided by fee-based technicians. VA asked a number of staff about this coverage, and their answers were inconsistent. This is troublesome because the coverage is less than the Handbook specifies, and because it indicates poor communication within the Medical Center. The Vascular Service Chief is actively recruiting two positions for the service and is working with Workforce Management to write updated position descriptions to improve staffing.

The lack of 24-hour availability of vascular technician staffing poses a risk to public health and safety.

Laboratory Staffing

VA interviewed staff from P&LMS along with many physicians and nurses, all of whom expressed concern about the timeliness of specimen transport to the laboratory. As specimens may be hand carried by transport personnel, nurses, or physicians,there is no standardized practice or functional policy in place. VA reviewed laboratory staffing documents and did not identify any deficiencies; however, concerns raised regarding the transit time should be analyzed.

[16] A Doppler ultrasound test uses reflected sound waves to see how blood flows through a blood vessel. It helps doctors evaluate blood flow through arteries and veins.

Suicide Prevention Teams

The former Suicide Prevention Coordinator (SPC) stepped down in February 2014. He had requested increased staffing three times during his tenure, and each request was denied, despite the fact that each social worker had more than 25 patients. During our investigation, the acting SPC said that he had hired four new social workers in Suicide Prevention, all of whom are on-board. There is also an additional SPC at a CBOC, and two case managers at the Medical Center. The case load is now 15–20 patients per social worker, and the Suicide Prevention Team now provides 24-hour coverage for the ED.

Conclusions for Allegation 4

- VA **substantiated** that prior to December 2012, significant nursing and physician staffing issues existed in the ED. However, they have been resolved.

- VA **substantiated** that, per VHA's *Emergency Medicine Handbook,* vascular technicians do not provide 24-hour services, and that the absence of this capability poses a risk to public health and safety. We are concerned that a complex facility such as the Medical Center must be able to conduct vascular ultrasound tests after hours. Currently, there is no one on-call, either in-house or under contract, to administer these tests and, if a Veteran were to have a serious medical condition, they would be unable to receive potentially life-saving diagnostics and treatment. If the Medical Center does not have the capacity to provide these services to any Veteran who may require them, it is placing all Veterans at risk.

- VA **did not substantiate** staffing shortages in laboratory services.

- VA **substantiated** that there were staffing shortages in the Suicide Prevention Team; however, these issues have been resolved, and the team is providing services in accordance with VHA policy.

Recommendation to the Medical Center

9. In conjunction with the VISN, immediately develop and begin implementing a plan to provide 24-hour coverage of the Vascular Service by qualified vascular service technicians.

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

has provided a legal review, and the Office of Accountability Review has examined the issues from a Human Resources perspective to establish accountability, when appropriate, for improper personnel practices. VA found violations of VA and VHA policy.

With respect to accountability, the Secretary takes this very seriously. He created the Office of Accountability Review (OAR) specifically to help investigate certain matters, including whistleblower retaliation claims, in order to help reset sustained accountability within VA. As OSC is aware, the individual who disclosed these matters (OSC File Number DI-14-2754) received expedited review of the related whistleblower reprisal allegations. Some of the Phoenix VA Medical Center leaders referenced in the retaliation claims are the same as those referenced in this report. Until the VA OIG and DOJ complete their ongoing criminal investigation at this facility, VA is unable to interview Phoenix VAMC leaders regarding the charges present in this report or the related retaliation claims. VA plans to review the results of the ongoing criminal investigation and to then complete its own administrative investigation to ensure that it has all relevant evidence before accountability actions are completed. VA will be happy to provide additional information on this matter as soon as it becomes available.

Attachment A

Documents in addition to the Eiectronic Medical Records reviewed.

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

Incident Reports related to ED visits from January 2003 through August 2014.

Organizational Chart for the Medical Center's Emergency Department.

Organizational Chart for the Medical Centers Ambulatory Clinics.

Phoenix VA Health Care System, Emergency Department Float RN Orientation List

Phoenix VA Health Care System, Emergency Department Lean System Redesign Project.

Phoenix VA Health Care System, Fiscal Year 14 Business Planning Contract, Medicine Service, August 7, 2013.

Phoenix VA Health Care System, Nursing Service Organizational Chart, April 2009-July 2014.

Phoenix VA Health Care System, Pathology & Laboratory Medicine Service Line Quality System Document, Collecting the Blood Sample, November 21, 2013.

Phoenix VA Health Care System, Patient Care Services Quality Council minutes, January 2009-July 2014.

Phoenix VA Health Care System, Position Management Committee Meeting Minutes, November 7, 2012.

Phoenix VA Health Care System, Position Management Committee Meeting Minutes, January 16, 2013.

Phoenix VA Medical Center, Ambulatory Care Policy No. 46, April 2012

VA Directive 0700, *Administrative Investigations*, March 25, 2002.

VA Handbook 5011, Hours of Duty and Leave, April 15, 2002.

VHA Directive 2009-069, *VHA Medical Facility Emergency Department Diversion Policy*, December 16, 2009.

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

VHA Directive 2010-011, *Standards for Emergency Departments, Urgent Care Clinics, and Facility Observation Beds*, March 4, 2010.

VHA Directive 2010-018, *Facility Infrastructure Requirements to Perform Standard, Intermediate, or Complex Surgical Procedures*, May 6, 2010.

VHA Handbook 1050.01, *National Patient Safety Improvement Handbook*, March 4, 2011.

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

VHA Surgical Complexity listing of all VHA Facilities
https://vaww.nso1.med.va.gov/vasqip/DUSHOMembeddedPages/complexity.aspx