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

The Special Counsel

November 27, 2018

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

Re: OSC File No. DI-17-5006

Dear Mr. President:

Pursuant to 5 U.S.C. § 1213(e)(3), I am forwarding to you a report from the Department of Veterans Affairs (VA) based on disclosures of wrongdoing within the Edward Hines, Jr. VA Hospital (Hines), Hines, Illinois. The whistleblower, who chose to remain anonymous, disclosed that Hines pharmacy management failed to properly oversee the facility's inpatient pharmacy. I have reviewed the agency report and whistleblower comments and, in accordance with 5 U.S.C. § 1213(e), provide the following summary of the report, whistleblower's comments, and my findings.[1]

The whistleblower alleged that [redacted], a clinical pharmacist in the Hines inpatient pharmacy, had a history of serious errors in processing patient prescriptions that compromised patient care. The whistleblower also alleged that Hines inpatient pharmacy management did not monitor the competency of employees in violation of agency policy.

The VA did not substantiate the whistleblower's allegations regarding [redacted] proficiency. The VA found that [redacted] error rate was within the accepted range for accuracy and that the errors reviewed were low-risk, causing no harm to patients. The VA did, however, acknowledge that Hines management had provided "unstructured, inconsistent, and ineffective" training to [redacted] and that his work schedule was not ideal. In response, the VA recommended that Hines develop a structured orientation process for new pharmacy staff, reevaluate its rotation schedule to allow pharmacists to recover between shifts, and update its policy regarding Heparin dispensing, which was found to be problematic. As of November 2018, these actions are either substantially underway or have been completed.

The VA substantiated that the Hines inpatient pharmacy supervisor had signed pharmacist competency assessment checklists after their September 30, 2017 completion deadline. Even though the checklist was signed past the deadline, the VA determined that the supervisor regularly reviewed and evaluated pharmacist competency throughout the year.

---

[1]The whistleblower's allegations were referred to former VA Secretary David J. Shulkin for investigation pursuant to 5 U.S.C. § 1213(c) and (d). The VA Office of the Medical Inspector conducted the investigation. VA Secretary Robert Wilkie reviewed and signed the agency's report.

The VA thus recommended that all checklists be completed and signed by the deadline, per agency policy, which the facility has begun to implement as of November 2018.

In addition to the referred allegations, the VA identified problems with high staff turnover in the inpatient pharmacy and tension between pharmacy leadership and union officials. In response, the VA recommended a consultative site visit with the National Pharmacy Benefits Management Program Office to assess Hines's pharmacy service and coordination with employee relations to provide training on labor-management relations and collective bargaining agreements. According to the VA, these actions are ongoing, and the VA will continue to monitor their implementation.

The whistleblower expressed continued concern about [redacted] competence and the level of risk associated with his errors. The whistleblower also noted an additional error that occurred after referral of these allegations and highlighted [redacted] repeated administrative mistakes.

I have reviewed the original disclosure, agency report, and whistleblower comments. While the agency did not substantiate all of the whistleblower's allegations, it did identify several areas for improvement and implemented enhanced policies to correct these deficiencies. In light of these responses, I have determined that the report appears reasonable and meets all statutory requirements.

As required by 5 U.S.C. § 1213(e)(3), I have sent a copy of this letter, the agency report, and the whistleblower's comments 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 the redacted § 1213(c) referral letter in our public file, which is available at www.osc.gov. This matter is now closed.

Respectfully,

Henry J. Kerner
Special Counsel

Enclosure