Department of Veterans Affairs

Office of Inspector General

SPECIAL INQUIRY

MANAGEMENT, CLINICAL, AND ADMINISTRATIVE ISSUES AT THE VA CENTRAL ALABAMA VETERANS HEALTH CARE SYSTEM (CAVHCS)

Report No. 8PR-G03-144
Date: September 29, 1998

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Washington, DC 20420

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington DC 20420

SEP 29 1998

To: Chief Network Officer (10N)

Subject: Special Inquiry, Management, Clinical, and Administrative Issues at the VA Central Alabama Veterans Health Care System, Report No. 8PR-G03-144

1. The Department of Veterans Affairs (VA) Office of Inspector General (OIG) reviewed numerous allegations of mismanagement, misconduct, poor clinical care practices, criminal activity, and administrative irregularities at the VA Central Alabama Veterans Health Care System (CAVHCS). The review was initiated at the request of Congressman Terry Everett, Chairman, Subcommittee on Oversight and Investigations, House Committee on Veterans' Affairs, who received allegations from multiple sources. In addition, the Deputy Secretary received allegations of personnel irregularities and reprisal against employees in December 1997, and asked that we also review these issues. The purpose of the review was to determine whether the complaints were valid.

2. We received several allegations pertaining to the personal conduct of, and appropriateness of certain management decisions made by the Director of the CAVHCS, Mr. Jimmie Clay. Some allegations were unsubstantiated. We did, however, substantiate that the Director improperly spent funds to renovate his and the Associate Director's quarters, misused his Government credit card, inappropriately attempted to use appropriated funds for an employee picnic, and he impeded OIG efforts to investigate issues. We also found that the Director used appropriated funds for a personal purchase and then attempted to cover it up by providing false and misleading information. In addition, we substantiated that the Director engaged in prohibited personnel practices by retaliating against one or more employees for whistleblowing.

3. We received allegations pertaining to the personal conduct of, and appropriateness of certain management decisions made by the Associate Director, Mr. John Hawkins. We substantiated excessive claims for reimbursement associated with the Associate Director's permanent change of station move to the VA Medical Center in Saginaw, Michigan, and more recently to the CAVHCS. Further, we substantiated that the Associate Director attempted to pressure subordinates to inappropriately spend appropriated funds for an employee picnic, permitted questionable purchases, and attempted to interfere with an OIG investigation. We also substantiated that the Associate Director violated nepotism laws by advocating the employment of his son, and he engaged in prohibited personnel practices by retaliating against one or more employees for whistleblowing.

4. We substantiated allegations that five former service chiefs who engaged in protected activities, such as filing grievances or Equal Employment Opportunity complaints, and who cooperated with our office, were victims of retaliation. We concluded that each of the service chiefs either engaged in a protected activity or was suspected by management of having been involved in a protected activity. We found that the protected activities occurred at or around the same time that these employees were non-selected to new positions or reassigned. Management's negative reaction to the employees engaging in protected activities and efforts to dissuade them from cooperating with the OIG supports our conclusion and recommendation for corrective action for these employees.

5. The VA Office of the Deputy Assistant Secretary for Human Resources Management (HRM) assigned two HRM professionals to work with our office in this inquiry. We also received assistance from a HRM manager who participated in other facility integrations. The VA HRM team found numerous regulatory and procedural violations, such as management's failure to consider and implement Reduction-in-Force regulations for some integrated service chief positions. Some violations were so significant that some individuals selected as new service chiefs will have to be displaced. Other violations can be resolved with lesser actions. The HRM team also found numerous regulatory and procedural violations in the staffing of three patient ombudsman positions, including ten candidates whose applications were rated and ranked, but were not considered for promotion. Because of the volume and seriousness of the violations, we believe an outside HRM professional will need to be assigned to current local human resources staff on a temporary basis until corrective actions are completed.

6. Upon beginning this review, there were a number of discrimination issues brought to our attention. However, because we continued to receive complaints of discrimination and racism at the facility, we forwarded the information gathered and all additional allegations to the VA Office of Resolution Management (ORM). The ORM office was created for the purpose of independently reviewing these matters. ORM will report its findings directly to the Veterans Health Administration.

7. Our healthcare inspectors substantiated some allegations involving instances of inappropriate patient care at the East and West Campuses. We found that, in three cases, clinicians should have admitted West Campus patients for care sooner. We also found that clinical managers did not always aggressively follow findings related to issues of inappropriate physician performance. We found the distribution of nursing staff on a shift by shift basis warranted management attention to ensure adequate coverage on the wards. We also found that clinicians did not always properly manage the administration of enteral (tube feeding) nutrition. We identified one East Campus patient that had been physically abused, but no one was disciplined. We also substantiated allegations that the East Campus had insufficient staff to provide a full range of needed respiratory therapy services, and that appropriate liquid medications were not being provided for Nursing Home Care Unit patients. The review also substantiated that Medical Officer of the Day procedures could be improved, West

Campus managers did not adequately investigate medication errors, and East Campus cardiac monitor alarms in the Intensive Care Unit and Emergency Room were set too low. We also found that an East Campus code team was unable to enter a building to respond to an emergency, and the process by which clinicians evaluated "code green" effectiveness was not followed. In addition, we substantiated deficiencies concerning the cleanliness of the East Campus. Approximately 50 percent of the 53 health care related allegations we reviewed were not substantiated.

8. During the course of our review of allegations, our health care inspectors performed collateral reviews of quality management practices. We found that managers need to concentrate on improving performance on diabetes mellitus indicator monitors, and more aggressively deal with methods for preventing patients from falling. We also found inadequate documentation of patients who were on special observations for suicidal precautions in the East Campus psychiatry units. Many of the health care related problems identified by the OIG at the CAVHCS were discussed with the Team Leader of a Veterans Health Administration (VHA) Quality of Care Review Task Group that subsequently visited the facility from February 2-4, 1998. The Task Group confirmed many of the problems previously identified by the OIG, and made similar recommendations for corrective action.

9. We substantiated allegations that the Chief, ***(b)(6)*** Service at the West Campus inappropriately operated a private business during his tour of duty, and that the former Chief, ***(b)(6)*** Service at the East Campus misused Government vehicles and misspent funds. We also found that certain employees at the East Campus misused their Government credit cards. While we did not substantiate that an East Campus timekeeper for the Nursing Service was fraudulently posting overtime, we found vulnerabilities in the method of recording and documenting overtime. Furthermore, we substantiated that East Campus Nursing Service staff took excessive sick leave, and that management did not adequately monitor or control its use. We also substantiated that fire and smoke alarm systems at the East Campus did not function properly.

10. We made 74 recommendations to the Chief Network Officer; Director, Veterans Integrated Service Network (VISN) 7; and Director, CAVHCS, and proposed that they take appropriate administrative actions, and correct the deficiencies identified during this review. We also invited VHA officials to form an independent working group comprised of attorneys and human resources management specialists to review our working papers and assess for themselves the integrity of the evidence regarding recommendations for appropriate administrative action in the report. This working group spent several weeks evaluating the evidence we collected during the review, and also interviewed employees at the CAVHCS to clarify issues further. The working group reported its findings to the Chief Network Officer in order to assist him in the preparation of his comments to this report.

11. VHA concurred, or partially concurred, with 68 of the 74 recommendations, and stated that actions had been taken, or were planned, to resolve the issues. VHA's reply to these issues was responsive or met the intent of our recommendations, and should begin to improve many of the conditions identified at the CAVHCS.

12. Of the remaining six responses, VHA deferred comment on recommendation 1.b. that the Director's and Associate Director's quarters be reappraised, pending the issuance of an OIG Office of Audit report on the Quarters Management Information System (QMIS). The audit report will specifically address the adequacy of the QMIS system, and the need for quarters operations. Regarding recommendation 1.c. that a bill of collection be issued to the Director to repay VA the cost of installing a new icemaker in his personal refrigerator, you agreed to take appropriate action based on the results of a follow up OIG review. The need to follow up recently became necessary because of conflicting testimonies and documents brought to our attention after the draft report was issued for comment. The follow up review was conducted and the results were forwarded to VHA for appropriate action. We will continue to follow up on these issues and recommendations until they are fully resolved.

13. VHA did not concur with recommendations 4.e., 4.f., and 4.g. to take corrective action on behalf of three employees who we concluded were retaliated against by VA management. The employees have filed, or have been notified of their right to file, a complaint with the Office of Special Counsel. This will provide the three employees with due process in resolving their complaints. VHA also did not concur with our recommendation 4.a. to take appropriate administrative action against the CAVHCS Director for engaging in prohibited personnel practices. We have referred this matter to the Deputy Secretary for resolution.

14. Allegations concerning certain criminal activities at the CAVHCS continue to be reviewed by investigative staff, and will be reported separately from this report. We will continue to follow up on all recommendations to ensure they are resolved. The full text of VHA's comments and implementation plans are shown in Appendix B of this report.

(Original signed by:)
JON A. WOODITCH
Assistant Inspector General for Departmental
Reviews and Management Support

CONTENTS

SPECIAL INQUIRY

MANAGEMENT, CLINICAL, AND ADMINISTRATIVE ISSUES AT THE VA CENTRAL ALABAMA VETERANS HEALTH CARE SYSTEM

REPORT NO. 8PR-G03-144
(Hotline No. 7HL-535/8HL-205)

PART I

INTRODUCTION

Purpose

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) examined numerous allegations of mismanagement, misconduct, poor clinical care practices, criminal activity, and administrative irregularities at the VA Central Alabama Veterans Health Care System. We initiated this review in June 1997 at the request of Congressman Terry Everett, Chairman, Subcommittee on Oversight and Investigations, House Committee on Veterans Affairs, who received allegations from multiple sources. In addition, while on site, numerous other complainants brought allegations to our attention directly. The Deputy Secretary received additional allegations of personnel irregularities and reprisal against employees in December 1997 and he asked that we review these issues as well. The purpose of this review was to determine if the complaints were valid.

Background

The VA Central Alabama Veterans Health Care System (CAVHCS) is the result of the integration of the Montgomery and Tuskegee, Alabama VA Medical Centers (VAMC). The CAVHCS is within the Veterans Integrated Service Network (VISN) 7, one of 22 networks created by VA nationwide to improve the delivery of health care services to our nation's veterans. The integration of Montgomery with Tuskegee is currently underway. Other VISN's have initiated facility integrations in geographical locations throughout the nation. Mr. Larry Deal is the Director of VISN 7.

Pre-integration

VAMCs in Montgomery and Tuskegee, Alabama operated separately for many years prior to 1996. Although only 35 miles apart, the Montgomery and Tuskegee campuses present several stark contrasts. VAMC Montgomery is a newer, centralized complex in an urban setting in the state capital. VAMC Tuskegee is an older facility with a cluster of 45 buildings on 160 acres in a small town and rural setting.

In late 1996, the Director of the Montgomery VAMC was Mr. John Rowan. For the purpose of this report, the senior staff consisted of: **(b)(6)**; **(b)(6)**; **(b)(6)**, Chief of **(b)(6)** Service (**(b)(6)**); **(b)(6)**, Chief of **(b)(6)** Service (**(b)(6)**); **(b)(6)**, Chief of **(b)(6)** Service (**(b)(6)**); **(b)(6)**, Chief of **(b)(6)** Service (**(b)(6)**); **(b)(6)**, Chief of **(b)(6)** Service (**(b)(6)**); and **(b)(6)**, Chief of **(b)(6)** Service (**(b)(6)**).

In late 1996, the Director of VAMC Tuskegee was Mr. Jimmie L. Clay. The pertinent senior staff were: **(b)(6)**, Chief of **(b)(6)**; **(b)(6)**, Chief of **(b)(6)** Service; **(b)(6)**, Assistant Chief of **(b)(6)** Service; **(b)(6)**, Chief of **(b)(6)**; **(b)(6)**, Chief, **(b)(6)** Service; and **(b)(6)**, Chief of **(b)(6)** Service. Other incumbent service chiefs retired or transferred before the events at issue in this report and are omitted. Mr. Robert Rollins, the incumbent, applied for the Associate Director position at the CAVHCS, however, the Director selected Mr. John Hawkins for the assignment.

Initial Integration Steps

On September 10, 1996, the Secretary of Veterans Affairs and the Under Secretary for Health approved the VISN 7 proposal to integrate the Montgomery and Tuskegee VAMCs. The integration had been under informal consideration since 1986 and the subject of feasibility studies since May 1996. In October 1996, Mr. Clay was named as Lead Director for the integration. Mr. Rowan, the Montgomery VAMC Director, retired in early January 1997. In mid-January 1997, Mr. Clay was named as the Director of the integrated facility. In April 1997, Mr. John Hawkins was selected as the Associate Director, CAVHCS. The Montgomery facility was designated the West Campus and the Tuskegee facility the East Campus of CAVHCS. Throughout this report, Montgomery is used interchangeably with West Campus and Tuskegee with East Campus.

Congressman Everett's Involvement and Requests for Assistance

In February 1997, Congressman Everett began receiving complaints, questions and allegations from employees and veterans regarding integration plans and mismanagement at the Tuskegee Campus. His concerns regarding the integration began to escalate in March 1997, as veterans, veterans' service organizations, and VA employees continued to contact his office. In response to some of these concerns, Congressman Everett requested that the General Accounting Office (GAO) study the plans for integration. This study was recently initiated, as GAO staff received the final CAVHCS integration plan in April 1998.

On May 25, 1997, Mr. John Hawkins' appointment as the Associate Director, CAVHCS was effected. On June 4, 1997, Mr. Hawkins began working with the VAMC Atlanta in

Decatur, Georgia, to announce other CAVHCS management positions. Mr. William Lamm, Chief, HRM, VAMC Atlanta, was asked to provide support.

Congressman Everett met with our office on June 5, 1997, to discuss numerous allegations of improprieties about the VAMC Tuskegee Campus. Congressman Everett requested an OIG investigation of these allegations and provided a list of complainants.

In November 1997, CAVHCS management announced selections for various administrative service chief positions. In December 1997, Congressman Everett contacted the Deputy Secretary because his office began receiving complaints of unfair treatment, retaliation for whistleblowing, and discrimination in the selection of these service chief positions. The Deputy Secretary contacted the Inspector General and asked that we include these issues in our review.

Other External Reviews

Several reviews of activities at the East and West Campuses had been completed, or were underway, at the time of our initial site visit to CAVHCS in June 1997. In October 1996, prior to the integration of the East and West Campuses, VA's Office of the Medical Inspector issued a report on the quality of surgical care at the Montgomery facility. The Medical Inspector reported that its site visit, conducted in October 1995, found serious deficiencies in many areas affecting the quality of patient care, and that top managers exacerbated or contributed to those deficiencies. Further, about the time we initiated this review, our Office of Investigations completed an investigation, which resulted in the conviction of a former service chief at the East Campus for filing false claims with the Government.

Scope

For the purpose of reviewing the issues relating to the selection of the administrative service chief positions and three patient ombudsman positions, we visited CAVHCS on two occasions. We interviewed more than 35 witnesses under oath, most of them more than once. We also reviewed numerous documents relating to the integration, the position announcements, the selections, personnel files, as well as documents provided by various witnesses. Because of allegations of technical violations of personnel laws and regulations, we had a team of two personnel specialists from VA Office of Human Resource Management (HRM), and one midlevel personnel manager from another medical center accompany us on the review.

Although the allegations were related to the selections for five of the service chief positions, · ***(b)(6)*** · · ·, · ***(b)(6)*** · · · · · · ·, · ***(b)(6)*** · · · · · ·, · ***(b)(6)*** · and · ***(b)(6)*** · · · · · · · · · · · · · · · ·and the patient ombudsman positions, the scope of our review included all integrated administrative service chief positions that were selected between May and December 1997. In addition, we reviewed various other related personnel actions that affected the complainants and their services. The results of the review of the service chief positions are contained in Part III of this report.

We reviewed concerns raised by Congressman Everett and others, and associated issues we ourselves identified. Specifically, in Part II of this report, we examine issues relating to the personal conduct of, and management decisions made by, Mr. Clay and Mr. Hawkins. Part IV of this report addresses clinical issues, and Part V addresses administrative issues.

All components of the OIG participated in this review. The OIG Office of Healthcare Inspections, including three registered nurses, a registered dietitian and a certified social worker, made four site visits to CAVHCS to assess clinical issues. In addition, an Office of Healthcare Inspections physician reviewed medical records, and three nurse-consultants and two physician-consultants assisted in nurse staffing analyses, medical records reviews, and evaluations of clinical issues. The inspection team members interviewed approximately 132 individuals, including patients, nurses, dietitians, social workers, physicians, podiatrists, pharmacists, quality management staff, administrative staff, and family members. The team obtained technical advice and consultation from several Veterans Health Administration managers and researchers. The team also reviewed approximately 98 medical records and associated quality management records, personnel files, credentialing and privileging records, and minutes of meetings. This inspection was conducted in accordance with the Quality Standards for Inspections published by the President's Council on Integrity and Efficiency.

Regarding our review of management and administrative issues, OIG Hotline and Special Inquiries Division program analysts, assisted by OIG Office of Audit staff, visited CAVHCS for a total of 12 weeks between July 1997 and January 1998. At least three staff were actively involved in the on-site work, conducting interviews and gathering pertinent documentation. The program analysts and auditors interviewed over 100 current and former employees of the East and West Campuses, including Mr. Clay, Mr. Hawkins, current and former service chiefs and other management officials, and clinical and administrative staff. Generally, the interviews were tape-recorded and testimony was taken under oath. The program analysts and auditors also reviewed and analyzed purchase orders, time and attendance records, Government American Express and other charge card records, travel vouchers, fiscal documents, personnel and medical records, and a variety of formal and informal reports and correspondence. Furthermore, we identified and applied pertinent laws, regulations, and policies.

To the extent that the OIG's Office of Investigations has resolved allegations of criminal activity, they are addressed in this report. The Office of Investigations is continuing its investigative work on several other matters.

PART II

SENIOR MANAGEMENT ISSUES

Issue 1:	**Personal Conduct of, and Management Decisions Made by, the CAVHCS Director**

We received several allegations, which we substantiated, pertaining to Mr. Clay's personal conduct and to the soundness of certain of his management decisions. We substantiated that Mr. Clay improperly spent funds for his and Mr. Hawkins' on-station quarters, misused his Government credit card, used appropriated funds for a personal purchase, attempted to spend appropriated funds for an employee picnic, attempted to interfere with our ability to thoroughly review the issues, and failed to take appropriate action against an employee whose behavior was questioned on multiple occasions. We also received several allegations regarding Mr. Clay that we did not substantiate.

Allegation 1: Mr. Clay improperly spent funds on his and the Associate Director's quarters.

We substantiated that Mr. Clay improperly spent funds on improvements to his and the Associate Director's quarters, both located on the East Campus. We found that, because Mr. Clay did not obtain the proper approvals, he spent $83,522 more than he should have on both quarters. Furthermore, Mr. Clay did not ensure that, when the work was completed, the two quarters were reappraised to reflect their up-to-date market values.

Between September 1996 and August 1997, Mr. Clay spent $178,141 to improve his and the Associate Director's quarters. Between September and December 1996, he spent $98,630 (including $9,035 for architectural and engineering services) to waterproof the basement of the Director's quarters, and at least $18,968 to install a new central heating and air cooling system. The Director's quarters were built in 1938 and Mr. Clay has occupied the unit for 11 years. Between June and August 1997 he spent $60,543 to remodel the interior of the Associate Director's quarters, including installing new kitchen appliances and countertops, bathroom fixtures, carpeting, drywall, ceiling fans, and wall light fixtures. In addition, most of the quarter's interior walls were painted, and miscellaneous electrical work was accomplished. The quarters were built in 1923. Mr. Hawkins moved into the quarters on August 16, 1997.

Mr. Clay spent more than he should have to renovate his and the Associate Director's quarters.

At the time the renovations were made, VA field facilities were directed to follow guidance in VHA Directive 10-93-014 regarding quarters maintenance and repair. That Directive required that individual quarters units be self-sustaining, meaning that they "must have the ability to recapture <u>all</u> expenditures through the collection of rent over an ensuing 10-year period." The Directive provided a formula for analyzing quarters'

income and expenses to determine its sustainability. The Directive further required that quarters not be continued for such use if the building reached a state of disrepair, which required alterations, improvements, or modernization or renovations that could not be recaptured in the ensuing 10-year period, unless Central Office approval was obtained. We found that Mr. Clay allowed funds to be spent to renovate his and the Associate Director's quarters in an amount that made the units no longer self-sustaining, and did not obtain the required approval to do so.

The former ***(b)(6)*** at the East Campus told us he did not prepare income and expense analyses of the two quarters prior to initiating the work. He said he did not prepare the analyses until OIG staff asked for them. The analyses prepared at that time clearly indicated that the improvements made in the Director's quarters and in process in the Associate Director's quarters caused both units to operate at a loss. For the Director's quarters, the analysis revealed a deficit of $43,562, and, for the Associate Director's quarters, the analysis revealed a deficit of $24,507. The deficit for the Associate Director's quarters subsequently increased to $39,960 because the final cost of remodeling those quarters exceeded the estimate used at the time the analysis was made. Therefore, according to the income and expense analyses, an excess amount of $83,522 was spent to renovate the two quarters.

Mr. Clay told us that, regarding his quarters, he never discussed with Engineering Service staff whether the planned expenditures would cause the quarters to operate at a loss. He said he relied on Engineering Service staff to ensure that all requirements regarding quarters were met. Mr. Clay emphasized that the waterproofing project was clearly needed. The OIG Office of Investigations is in the process of determining if the project was properly procured and the work properly billed.

Regarding the Associate Director's quarters, Mr. Clay told us he discussed the remodeling costs with Engineering Service management staff and with the former Associate Director, but that he never knew exactly how much the project would cost. He said he was told sufficient station funds were available to pay for the remodeling but he was never told the quarters would be operating at a deficit. The Director also stated that he thought the remodeling costs were supposed to be spread over the anticipated life expectancy of the building rather than over a 10-year time period, as required by VHA Directive 10-93-014.

We identified several questionable purchases that contributed to the overspending on the Associate Director's quarters. For example, two separate central air conditioning systems, one having a cooling capacity of 5 tons and the other having a cooling capacity of 4 tons, were installed at an estimated cost of $11,575. The systems, including ductwork, were installed to replace window air conditioning units and an antiquated steam heating system. However, according to a VA Central Office engineer in the Veterans Health Administration's Office of Facilities, even under the most adverse conditions, the quarters should not have required more than 1 ton of cooling capacity per 500 square feet, or 5.5 tons. Mr. Hawkins himself acknowledged that the air conditioning system was excessive.

A second questionable purchase for the Associate Director's quarters were toilet flush valves. Two new toilets were purchased for the quarters. The toilets were of a commercial design, which used flush valves instead of water tanks. The flush valves purchased were chrome plated and cost $66 each. A week after the original purchase order was dated, two additional polished brass flush valves were ordered for the toilets. The polished brass valves were otherwise identical to those originally ordered. They cost $267 each, and were delivered overnight at an additional cost of $60. We were told that the chrome plated ones were used elsewhere in the facility. Because of conflicting testimony, we could not determine who made the decision to order the brass valves.

Mr. Clay did not obtain the proper approvals to proceed with the renovations.

VHA Directive 10-93-014 required VA Central Office approval for facilities to spend funds on quarters when the income and expense analysis indicated the expenditure could not be recaptured in the ensuing 10-year period. When requesting Central Office approval, facilities were required to submit a justification for retaining the unit, a detailed cost estimate, and the income and expense analysis.

We found no indication that Mr. Clay received VA Central Office approval for the renovations made to his quarters or to the Associate Director's quarters. Mr. Clay did receive tentative approval from the VISN 7 Director to proceed with the renovations to his quarters. On September 13, 1996, Mr. Clay prepared a memorandum to the VISN Director requesting approval to repair water leaks in his basement and install a new central heating and air cooling system in the quarters. The VISN Director told us he verbally indicated to Mr. Clay support for the proposed work and requested a project submission and justification for his review and approval. However, according to the VISN Director, he never received the requested information.

Mr. Clay did not ensure that, when the work was completed, the quarters were reappraised to reflect their up-to-date market values.

VHA Directive 10-93-014 required that appraisals of quarters be performed every 5 years, or when alterations, improvements, or reconditioning affected the quarters' value. According to documentation provided to us by the East Campus' former ***(b)(6)*** the last appraisals for the Director's and Associate Director's quarters were made in March 1992. An appraisal should have been performed on the Director's quarters in January 1997, after the basement waterproofing project was completed and the new heating and air cooling system was installed. An appraisal should have been performed on the Associate Director's quarters in August 1997 after the interior of the quarters was remodeled. The former ***(b)(6)*** told us that, as of January 1998, these appraisals had not been done. Mr. Clay testified that he was aware new appraisals were required periodically, but he said he did not know one was required following a significant improvement or alteration.

Allegation 2: Mr. Clay misused his Government Credit Card.

We substantiated that Mr. Clay misused his Government American Express card on two occasions between October 1994 and June 1997. According to VA regulations (MP-1, Part II, Chapter 2, Appendix M, Section 8a), employees may use their Government American Express card while they are on official travel for official purposes only. The regulations state that "personal expense items purchased during travel status are to be obtained with cash or through personal credit."

We reviewed monthly activity reports provided by American Express, as well as Mr. Clay's travel and time and attendance records, from October 1994 through June 1997, and found that he misused his card as follows:

- On March 13 and 14, 1995, Mr. Clay attended a conference, on official business, in New Orleans, Louisiana. While there, he charged $456 on his Government American Express card for the cost of an extra room for his son, who had accompanied him on the trip. Mr. Clay told us he was not aware that he had to separate official and personal expenses when he was on official travel. Nevertheless, as Director, Mr. Clay should have known not to use his card for personal expenses.

- On August 9 and 10, 1996, while on annual leave, Mr. Clay incurred $49 in lodging expenses in Mansfield, Louisiana. There was no travel voucher to support the charge. Mr. Clay told us the expense was a personal one, not associated with any authorized Government travel. He said he accidentally pulled his Government American Express card from his wallet and used it to pay his hotel bill.

Allegation 3: Mr. Clay used appropriated funds to repair his personal property.

We substantiated that Mr. Clay used $202.98 of appropriated medical care funds to purchase and install a new icemaker in his personal refrigerator, which he kept in his on-station quarters. Appropriated funds may not be used to purchase personal furnishings for employees.

We reviewed two work orders relating to the February 1997 purchase and installation of the icemaker. According to the first work order, East Campus Engineering Service staff spent $175.00 to purchase the icemaker and spent one hour, at a cost of $13.99, to install it. According to the second work order, Engineering Service staff returned to the Director's quarters to check their work, again at a cost of $13.99.

Mr. Clay told us the refrigerator was his personal property, and that, when it began leaking, he asked the Engineering Service staff to find out what was wrong. He said he was aware that the icemaker was being purchased with appropriated funds and had initially asked that he be sent a bill covering the expense. However, he said he never received a bill and never repaid VA for the costs incurred.

Allegation 4: Mr. Clay attempted to use appropriated funds for an employee picnic.

We found that Mr. Clay was aware that the Associate Director planned to improperly fund an employee picnic. As discussed in detail later in this report, Mr. Hawkins planned to use $25,000 in appropriated funds to pay for a September 1997 employee picnic. Mr. Clay told us that an employee recognition activity was included in the agenda so appropriated funds could be used. In general, appropriated funds cannot be used to purchase refreshments for employees. However, under the Federal Incentive Awards Program, light refreshments may be provided at ceremonies where incentive awards are given.

Mr. Hawkins referred to the picnic as CAVHCS's employee awards ceremony. The picnic was scheduled to last 8 hours. We were told that the plan was not to present awards but to have the Director read the names of some award recipients. Employees were invited to "pig out" on unlimited servings of pizza, hot dogs, smoked sausage, hamburgers, chicken sandwiches, potato salad, chips and more. We do not consider such a menu "light refreshments." Furthermore, plans for the picnic included entertainment, such as bingo games, children's rides, and live music, none of which, by law, can be paid from appropriated funds. We concluded that the decision to read the names of award recipients was an improper attempt to circumvent Federal regulations to pay for employee refreshments.

Allegation 5: Mr. Clay interfered with an OIG review.

During the course of our inquiry, Mr. Clay interfered with our efforts on several occasions. In the first instance, on September 22, 1997, Mr. Clay sent an e-mail message to service chiefs in CAVHCS instructing them to inform all employees that anyone having telephone contact with the OIG must immediately prepare a report regarding that contact. After we discussed Mr. Clay's action with the VISN Director, he instructed Mr. Clay to retract the directive. Mr. Clay did so on September 25. However, the initial directive could have intimidated some employees, and caused them to be reluctant to provide us information.

On a second occasion, in a November 19, 1997 memorandum, Mr. Clay declined to provide us information we requested regarding the selection of several service chiefs. We requested this information in response to allegations of reprisal and discrimination. Mr. Clay stated that the information was sensitive and, unless we could give him a specific reason why we wanted the documentation, he believed such matters were generally not within our purview. This eventually became the subject of a separate special inquiry, the results of which are included in Part III of this report.

We also noted that Mr. Clay was reluctant to suspend a former service chief after she was indicted on criminal charges stemming from an OIG Office of Investigations case. VA regulations [MP-5, Part I, Chapter 752, Section 11(4)(a)] provide that an employee may be suspended with as little as 7 days notice "where there is reasonable cause to

believe the employee has committed a crime for which a sentence of imprisonment may be imposed." Mr. Clay told us he was hesitant to remove or limit the duties of the service chief because the charges had not been proven. However, the seriousness of the charges and the potential for further irregularities necessitated, in our opinion, the service chief's suspension. After we brought this matter to the attention of the VISN Director, Mr. Clay did suspend the individual.

Allegation 6: Mr. Clay did not take appropriate administrative action against an employee whose behavior was questioned on multiple occasions.

We substantiated that Mr. Clay failed to take appropriate administrative action against an employee whose behavior toward patients and co-workers was questioned on numerous occasions. The employee, ***(b)(6)***, was involved in a physical altercation with another employee in February 1996 and, as a result, was given a proposed removal notice in March. However, on April 19, 1996, ***(b)(6)*** agreed to a 14 day suspension and management (the former Associate Director) agreed to hold the removal notice in abeyance for one year. According to the agreement signed by both parties, if ***(b)(6)*** did not meet all conditions of her employment, management would take appropriate action based on the proposed removal.

On two occasions in April 1997, before the April 19, 1996 abeyance agreement expired, ***(b)(6)***'s behavior was again called into question. In the first instance, a Board of Investigation found that ***(b)(6)*** verbally abused a patient by yelling at him. Although Mr. Clay concurred with the Board's recommendation to take appropriate administrative action, no such action was ever finalized. In the second instance, ***(b)(6)*** was involved in a physical altercation with another employee. Mr. Clay decided not to effect ***(b)(6)***'s removal because he was not certain she initiated the altercation. Rather, ***(b)(6)*** was suspended for 3 weeks.

In June 1997, ***(b)(6)*** was again alleged to have abused a patient, this time physically. A Board of Investigation reported it could not substantiate the alleged abuse, but it did conclude that the patient sustained an injury while under ***(b)(6)***'s care. Again, while Mr. Clay concurred with the Board's recommendation to take appropriate administrative action, no action was ever taken. According to the Special Assistant to the Director, pending the outcome of the Board's review, ***(b)(6)*** was reassigned to the Chief Nurse's office and placed under the guidance of an experienced preceptor who assisted her with improving her interpersonal skills. The Special Assistant noted that ***(b)(6)*** demonstrated considerable improvement.

After we discussed this employee's situation with Mr. Clay in November 1997, he reassessed the situation and determined that a termination would be unfair, especially in light of the fact that over 5 months had passed without appropriate follow-up action being taken. We believe management's prior inaction regarding this employee does not preclude them from taking further appropriate administrative action at this time (Also see section on Patient Abuse, Part IV, Issue 4 of this report).

Unsubstantiated allegations

We did not substantiate the following allegations against Mr. Clay:

- ***(b)(6)***

- A complainant alleged that Mr. Clay removed a wing back chair from his East Campus office suite and is using the chair in his on-station quarters. We reviewed all chair purchases by the East Campus for Fiscal Years 1996 and 1997, and identified 78 chairs described as being similar to a wing back design. We inventoried each chair, and found all of them in administrative or clinical areas of the East Campus.

- A complainant alleged that Mr. Clay inappropriately purchased coffee mugs from the East Campus Canteen Service. We reviewed a December 17, 1997 purchase order issued to the Canteen Service for 1,152 coffee mugs costing a total of $2,522. The message "Tuskegee – We Do It Better" was written on the side of each mug. We were told the mugs were given to patients who were at the East Campus during the 1997 Christmas season. The mugs were purchased from an office supplies account. We found nothing inappropriate about the purchase.

- A complainant alleged that Mr. Clay and other managers at the East Campus embezzled $50,000 from the East Campus' Nursing Service overtime account during the first quarter of Fiscal Year 1994. According to the complainant, fiscal records indicated that $91,000 had been spent on overtime during that quarter, but an analysis of overtime hours worked by Nursing Service staff could account for only about $41,000. We found no evidence that funds were embezzled, and during the first quarter of Fiscal Year 1994, records indicated that East Campus Nursing Service employees actually received about $99,000 in overtime payments. Allegations regarding inappropriate overtime payments are discussed in Part V of this report.

- A complainant alleged that Mr. Clay diverted Government funds to refurbish a house he owned in another state. We reviewed the property records in the locality where the house allegedly was located, and found no property owned by Mr. Clay or any member of his family. Mr. Clay told us he did own property elsewhere in that state, but denied he used Government funds to refurbish it. According to records maintained by that locality, no renovation or construction has occurred on that property since October 1994. The individuals currently renting the property told us they had lived there for 5 years and the house had not been remodeled or refurbished during that time.

- A complainant alleged that management did not disclose the murder of a nurse who was stabbed in an East Campus parking lot. Investigative work identified no evidence of any employee being murdered at the East Campus.

Conclusion

Mr. Clay spent $83,522 more than he should have to renovate his and the Associate Director's quarters. Had an analysis of income and expenses been done, it would have shown that the planned expenditures would make the quarters not self-sustaining and, therefore, subject to Central Office approval. However, Mr. Clay did not obtain the proper approvals to proceed with the renovations. When the work was completed, he did not ensure that the quarters were reappraised to reflect their up-to-date market values.

We also concluded that Mr. Clay was aware the Associate Director added an employee recognition activity to the agenda of a planned picnic so that appropriated funds could be used to pay the picnic expenses. Further, Mr. Clay failed to take appropriate administrative action against an employee whose behavior was questioned on numerous occasions.

Mr. Clay's personal conduct pertaining to three matters we reviewed was improper. He improperly used his Government American Express card on two occasions between October 1994 and June 1997. He used appropriated funds to have a new icemaker installed in his personal refrigerator and did not repay VA for the costs incurred. He also interfered with an OIG review and initially refused us access to information we requested.

Recommendation 1

The Director, VISN 7, should:

a. Take appropriate administrative action against Mr. Clay for improperly spending funds to renovate his and the Associate Director's quarters, attempting to use appropriated funds for an employee picnic, improperly using his Government credit card, and interfering with an OIG review.

b. Reappraise the Director's and Associate Director's quarters as of the date the renovations discussed above were completed, adjust the rent charged to Mr. Clay and Mr. Hawkins accordingly, and bill them for any retroactive rent due.

c. Ensure that a bill of collection is issued to the Director in the amount of $202.98 to repay VA for the cost of installing a new icemaker in his personal refrigerator.

d. Ensure that Mr. Clay takes appropriate administrative action against ***(b)(6)***, whose behavior towards patients and co-workers was questioned on numerous occasions.

VHA Comments

The Chief Network Officer concurred with recommendation 1.a., and agreed to take appropriate administrative action against Mr. Clay. The Chief Network Officer noted that Mr. Clay's misuse of his Government credit card was an innocent mistake and that his intentions regarding actions he took which interfered with our review could not be determined. The Chief Network Officer deferred commenting on recommendation 1.b. pending the completion of an OIG Office of Audit report on the Quarters Management Information System (QMIS), which established a new formula for determining rental rates. The Chief Network Officer concurred in part with recommendation 1.c., raising concerns that the evidence regarding this matter was somewhat contradictory. VHA deferred a final decision on this matter pending the outcome of a follow up review by the OIG. He stated VHA would take appropriate action based on the results of that investigation. Regarding recommendation 1.d., that the Director, VISN 7, take appropriate administrative action against ***(b)(6)***, the Chief Network Officer concurred that action should have been taken prior to the expiration of her settlement agreement. He noted other actions planned to reduce the possibility another incident would occur in the future. The Chief Network Officer's complete comments are in Appendix B.

OIG Response

Regarding recommendation 1.a., the Chief Network Officer's suggestion that the Director made an innocent mistake in misusing his Government credit card warrants further comment. We believe Mr. Clay's misuse of his credit card is an example of his indifference towards adhering to, and enforcing, Government credit card policies at the facility. Our evidence shows that management permitted small infractions of this nature when employees reimbursed the Government for unofficial transactions. However, since VA regulations prohibit employees from using Government credit cards for their personal use, management should have taken these infractions more seriously. Mr. Clay's disregard of these regulations is not representative of the type of behavior expected from a Medical Center Director who has the responsibility to not only enforce regulations, but to lead by example. This type of behavior can be construed as a contributing factor to other examples of credit card misuse at the CAVHCS. For example, we identified 10 employees at the East Campus who misused their credit cards by making inappropriate purchases and/or failing to pay the full balances due in a timely manner (See Part V).

Also regarding recommendation 1.a., we do not agree with the Chief Network Officer's comment that Mr. Clay's intentions in interfering with our review could not be determined. We believe Mr. Clay did intend such interference as demonstrated by the fact that he interfered with the OIG on more than one occasion. The Chief Network

Officer plans to propose administrative action against Mr. Clay on this issue, and we consider this responsive to the recommendation.

We agree with the Chief Network Officer's decision to delay action on recommendation 1.b. to reappraise the Director's and Associate Director's quarters and recoup any additional rent due the Government. We will follow up to ensure that this recommendation is satisfactorily resolved once the OIG Office of Audit issues its report on the QMIS program.

Regarding recommendation 1.c., the OIG conducted a follow up review to clarify inconsistencies between our draft report and subsequent testimony and evidence given by Mr. Clay and other VA staff. After our draft report was issued, Mr. Clay produced a cancelled check to · ***(b)(6)*** · · · · · · · · · · · · · · · , a subordinate employee, dated 4 days after he testified under oath to the OIG on October 27, 1997, that VA purchased and installed an icemaker in his personal refrigerator in February 1997. Mr. Clay contended in his comments to the draft report that the check was for the purchase of an icemaker from · ***(b)(6)*** · · · · · · · · , who not only works for the VA but also owns a private business. Mr. Clay indicated that · ***(b)(6)*** · · · · · · · · installed the icemaker on his own time as part of his private business concern. Mr. Clay testified under oath when interviewed on July 27, 1998, by the VHA review team that · ***(b)(6)*** · · · · · · · · installed the icemaker on a weekend prior to the date on the check. He also denied that an icemaker was installed in his personal refrigerator in February 1997, which was contrary to his testimony to us on October 27, 1997. In response to our draft report, Mr. Clay also produced statements from the employees identified on the February 1997 VA work orders as having installed the icemaker denying that they had any recollection of having installed an icemaker in Mr. Clay's refrigerator. Following are the results of the OIG follow up investigation.

> OIG Special Agents began collecting documentary and testimonial evidence on September 15, 1998. Mr. Clay, through his attorney, refused to be interviewed. His attorney advised our agent that unless we provided them with a copy of the transcript of Mr. Clay's interview with our office on October 27, 1997, no interview would be allowed. His attorney further advised that the dates suggested by our office for an interview were not convenient to either the attorney or Mr. Clay. Notwithstanding the absence of testimony from Mr. Clay, our investigation concluded: (1) that an icemaker was purchased with VA appropriated funds and installed in Mr. Clay's personal refrigerator in February 1997 on VA time; (2) that contrary to his testimony to the OIG on October 27, 1997, Mr. Clay did not request that he be issued a bill of collection for the icemaker installed in February 1997; (3) that after Mr. Clay was interviewed by the OIG on October 27, 1997, he called · ***(b)(6)*** · · · · · · · · and asked to have the VA icemaker replaced and did ask · ***(b)(6)*** · · · · · · · · for a bill for the new icemaker; (4) that · ***(b)(6)*** · · · · · · · · , through his private business, purchased another icemaker from Stinson Appliance Parts; and, (5) contrary to Mr. Clay's testimony under oath, the new icemaker was again installed by

a CAVHCS employee on Government time. We also found that the method in which Mr. Clay and Mr. Hawkins addressed this issue when presented with the OIG draft report constituted intimidation and coercion of CAVHCS employees which resulted in the signed statements that were submitted with the CAVHCS response, and in ***(b)(6)*** unnecessarily purchasing yet a third icemaker using his own funds. ***(b)(6)*** placed the third icemaker he bought in the Air Conditioning (AC) Shop so that it would appear that it was the icemaker purchased in February 1997.

During the follow-up investigation, ***(b)(6)***, Chief ***(b)(6)***, also confirmed that an icemaker was ordered for use in Mr. Clay's refrigerator on February 19, 1997. Two work orders dated February 18, 1997, and February 25, 1997, document VA employees ***(b)(6)***, and ***(b)(6)***, as having installed the icemaker on February 18th, and having returned to see if it was functioning properly on February 25th.

(b)(6) advised us that he was the Acting Chief ***(b)(6)*** Service when he approved the acquisition of the icemaker for Mr. Clay's quarters in February 1997. ***(b)(6)*** confirmed that the icemaker was a routine procurement and that the related work orders were valid.

(b)(6) followed ***(b)(6)*** as Acting Chief ***(b)(6)*** Service and advised us that she was a member of the response team formed to reply to the OIG draft report, dated April 24, 1998. ***(b)(6)*** said the team met with Mr. John Hawkins, Associate Director. ***(b)(6)*** recalled the group reviewing the icemaker issue and Mr. Hawkins expressing his opinion that employees falsified the work orders to cover their time. ***(b)(6)*** said she disagreed with this theory but could not offer a rebuttal because neither ***(b)(6)*** nor ***(b)(6)*** could recall replacing Mr. Clay's icemaker. ***(b)(6)*** did disclose that ***(b)(6)*** brought an icemaker into Mr. Hawkins' office and said that it was the icemaker purchased with the February 1997 requisition. ***(b)(6)*** later testified that this was a third icemaker, which he purchased with his own funds.

(b)(6) advised us that ***(b)(6)*** and ***(b)(6)*** replaced Mr. Clay's icemaker at VA expense in February 1997 and confirmed the validity of the requisition and work orders. ***(b)(6)*** said that the first work order was for the installation of the icemaker and the second work order was to have his men check out the icemaker to be sure that it was functioning properly. ***(b)(6)*** testified that Mr. Clay did not advise him that they were installing the icemaker into his personal refrigerator and that Mr. Clay did not ask for a bill of collection for the icemaker or the installation.

· ***(b)(6)*** · · · · · · · · said that in late October 1997, just after the OIG interviewed Mr. Clay regarding the February 1997 icemaker installation, Mr. Clay requested a service call to his residence regarding the icemaker. At this time, Mr. Clay and · ***(b)(6)*** · · · · · · · · agreed that he would replace the icemaker under the auspices of his own business and that Mr. Clay would pay · ***(b)(6)*** · · · · · · · · for the cost of the icemaker. · ***(b)(6)*** · · · · · · · · said he ordered the icemaker from Stinson's Appliance Parts, and when it was delivered to the CAVHCS, · ***(b)(6)*** · · · · · · · · had one of his employee's, · ***(b)(6)*** · · · · · · · · · · · · · · , install the item into Mr. Clay's refrigerator on VA time. · ***(b)(6)*** · · · · · · · · informed us that Mr. Clay gave him a $165 check, which covered the cost of the icemaker, but not installation charges.

· ***(b)(6)*** · · · · · · · · further stated that shortly after the OIG draft report was issued in April 1998, the Associate Director, Mr. Hawkins, called him into his office. · ***(b)(6)*** · · · · · · · · said that Mr. Hawkins was heavy-handed in his questioning about Mr. Clay's icemaker and made him feel that if he could not produce another one, his job would be on the line. · ***(b)(6)*** · · · · · · · · said that he was so upset over the matter and felt that his job was being threatened that he went out and purchased another icemaker at his own expense using cash and burned the receipt. · ***(b)(6)*** · · · · · · · · produced a copy of the invoice for the October 29, 1997 purchase. We are in the process of obtaining a copy of the invoice for his May 1998 icemaker purchase from the vendor.

· ***(b)(6)*** · · · · · · informed us that he could not argue with the work orders and requisition, as well as the AC Shop logbooks that showed Mr. Clay's icemaker was replaced by the VA in February 1997, but said he could not remember the incident. · ***(b)(6)*** · · · · · · · could not be interviewed because he had caught a flight the morning of the planned interview to go on a cruise. · ***(b)(6)*** · · · · · · · · recalled replacing Mr. Clay's icemaker on October 30, 1997, as recorded in the AC Shop logbook. · ***(b)(6)*** · · · · · · · · also recalled Mr. Clay's icemaker having been replaced by AC Shop employees in February 1997, because he heard them discussing it in the shop. · ***(b)(6)*** · · · · · · · · said that he had suggested that the warranty be pursued since the icemaker installed in February 1997 had only lasted eight months. The original logbooks have been seized.

Based on our follow up investigation, we concluded that in February 1997, Mr. Clay misused VA appropriated funds to purchase an icemaker for his personal refrigerator, and that he inappropriately had VA employees install the icemaker on VA time. We also found that once Mr. Clay was confronted over this issue by our office, Mr. Clay attempted to cover up the incident by having · ***(b)(6)*** · · · · · · · · install another icemaker. After the OIG draft report was issued, Mr. Clay and Mr. Hawkins provided VHA management and the OIG with misleading information, including the submission of two

questionable statements by · ***(b)(6)*** · · · · · · · and · ***(b)(6)*** · · · · · ·, in an effort to show that the only icemaker installed was paid for by Mr. Clay and was installed by a private business concern at Mr. Clay's expense. We also concluded that Mr. Clay did not testify truthfully when he gave testimony under oath during the October 27, 1997, OIG interview and during the July 27, 1998, interview conducted by the VHA review team.

In addition to ensuring that Mr. Clay reimburses the VA for the icemaker obtained in February 1997 and the VA time spent to install the icemakers into his personal refrigerator in February and in October 1997, the VISN Director should: (1) take administrative action against Mr. Clay for misusing appropriated funds and having his subordinate employees install icemakers into his personal refrigerator on VA time; (2) take appropriate administrative action against Mr. Clay for impeding the OIG in the review of this matter, and for submitting misleading and inaccurate information concerning the icemaker purchases and installations; (3) take appropriate administrative action against Mr. Clay for failing to testify truthfully on this issue during the OIG and VHA investigations; and, (4) take administrative action against Mr. Hawkins for his threatening behavior towards · ***(b)(6)*** · · · · · · · ·, and for Mr. Hawkins' attempt to provide the OIG with misleading and inaccurate information concerning the icemaker purchase and installation. We have communicated the results of our follow up investigation to the Chief Network Officer who indicated he would inform us of his final decision on this matter.

The Chief Network Officer's comments met the intent of recommendation 1.d., and we will follow up to ensure the corrective actions planned are taken.

Issue 2: Personal Conduct of, and Management Decisions Made by, the CAVHCS Associate Director

We received several allegations, which we substantiated, pertaining to Mr. Hawkins' personal conduct and to the soundness of certain of his management decisions. We substantiated irregularities associated with Mr. Hawkins' permanent change of station move to Tuskegee. Further, we substantiated that Mr. Hawkins attempted to pressure a subordinate to spend appropriated funds for an employee picnic, violated nepotism laws, permitted staff to spend more than necessary on safety shoes, and improperly approved moving a refrigerator purchased with appropriated funds into the Director's suite. We also received an allegation against Mr. Hawkins regarding an improper purchase, which we did not substantiate.

Allegation 1: Mr. Hawkins was reimbursed for excessive claims on travel vouchers associated with his permanent change of station move.

We substantiated that, pursuant to his permanent change of station move from Saginaw, Michigan to Montgomery, Alabama, Mr. Hawkins was reimbursed for excessive claims for meals. Mr. Hawkins was assigned to CAVHCS in Montgomery effective May 25, 1997, and began claiming expenses for temporary quarters when his wife and son joined him on June 10. He continued to claim expenses for temporary quarters for 67 days. Mr. Hawkins' temporary quarters included a kitchen. In addition, he paid and was reimbursed an extra $100 a month in rent for a "home living package," which included cooking and eating utensils.

According to Federal regulations in effect at the time of Mr. Hawkins' relocation, Mr. Hawkins could claim up to $200 a day for subsistence expenses for himself and his family during his first 30 days in temporary quarters. The regulations allocated this amount to lodging (up to $125) and meals and incidental expenses (a fixed amount of $75). After the first 30 days, Mr. Hawkins was authorized to claim $140 a day (up to $87.50 for lodging and $52.50 for meals and incidental expenses) for himself and his family. VA regulations [MP-1, Part II, Chapter 2, Section 13h(4)] further provided that an employee may be reimbursed actual subsistence expenses while in temporary quarters if the amounts claimed over a 30-day period were reasonable.

We reviewed the travel vouchers submitted by Mr. Hawkins in which he claimed reimbursement for his temporary quarters subsistence expenses. We found that the amount he claimed for food exceeded the allowable amounts and was not reasonable. We calculated that Mr. Hawkins could claim $4,091.25 for meals and incidental expenses for the 67 days he and his family were in temporary quarters. However, Mr. Hawkins claimed $6,886.85, or $2,795.60 more than he was entitled to claim. Mr. Hawkins' total daily claim for reimbursement, including his lodging expenses, did not exceed the total authorized rate ($200 a day during the first 30 days, and $140 for each subsequent day). He was reimbursed the $6,886.85 he claimed.

Mr. Hawkins told us he did not believe he had made an improper claim because he did not exceed the applicable total authorized rate. He told us he asked the newly appointed CAVHCS financial manager to review his vouchers and she told him his claims were appropriate.

We obtained Mr. Hawkins' vouchers covering his permanent change of station move to Saginaw and noted that he made similar claims at his prior duty station. After the in-route portion of his move, he stayed in temporary quarters for 90 days before his family joined him. The allowable amount for meals and incidental expenses at the time (March 15 through June 14, 1993) was $26 per day for the first 30 days and $19.50 for every day following the first 30 days. We calculated that Mr. Hawkins should not have claimed more than $1,833 for meals. We found that he claimed $3,224 in meal expenses. Consequently, he was reimbursed $1,391 more than he was allowed for his move to Saginaw.

We discussed Mr. Hawkins' vouchers with the Chief, Travel Policy Division, Ms. Bonnie Britten, in VA Central Office. She reiterated the VA regulation cited above, which provides that an employee in temporary quarters does not have to adhere strictly to the allocation limits applicable to lodging and meals and incidental expenses, as long as the amount claimed over a 30-day period is reasonable. However, she told us she believed that Mr. Hawkins' claims for meals, in excess of the authorized rate, were not reasonable. She expressed concern over why, if the VA Austin Finance Center selected Mr. Hawkins' voucher for audit, the auditors did not question this claim.

The Chief, Travel Policy Division referred us to an April 1997 Department of Agriculture publication that she said VA travel voucher auditors use to determine the reasonableness of claims for meals. According to this publication, under the most liberal plan, the average monthly grocery expenses for a family of three was $692, or $23 a day. Based on this, we concluded that the daily allowance for meals and incidental expenses Mr. Hawkins was authorized ($75.00 and $52.50) was reasonable. Mr. Hawkins told us he and his family ate all their meals in restaurants and that those meals tended to be expensive. His costs averaged $103 per day. However, considering VA paid an extra $100 a month for Mr. Hawkins and his family to have access to a fully equipped kitchen, we do not believe his meal claims were reasonable or in the best interest of the Government.

We also noted two days (August 14 and 15, 1997) for which Mr. Hawkins claimed meal expenses both on his permanent change of station voucher and on a voucher he submitted covering a temporary duty status. The Chief, Travel Policy Division told us this duplicate claim, in the amount of $45, was inappropriate.

While reviewing Mr. Hawkins' travel vouchers covering his permanent change of station move, we also found that he was reimbursed a total of $157.30 for coin-operated laundry services, which was in addition to his reimbursements for dry cleaning expenses. However, Mr. Hawkins' temporary quarters was equipped with a clothes washer and dryer.

Mr. Hawkins also failed to ensure that his vouchers properly noted that he had an outstanding travel advance. VA policy requires that employees ensure their vouchers are complete as to form, facts, details, and supporting evidence. The policy assigns responsibility for the correctness of all statements made on the voucher to the traveler. Mr. Hawkins received a $2,000 travel advance before leaving Saginaw, and received a second advance while he was in temporary quarters. However, he did not indicate on his vouchers that he had these advances. We reviewed Mr. Hawkins' vouchers covering his permanent change of station move to Saginaw, and found that he did indicate on those vouchers that he received travel advances. Therefore, we concluded that he was aware that the travel advances were to be included on his vouchers.

The two travel clerks at CAVHCS who were involved in preparing Mr. Hawkins' vouchers told us they assumed responsibility for ensuring that Mr. Hawkins' advances were noted on his vouchers. One clerk told us she did note the existence of an advance on the bottom of the voucher, but not in the space designated for that purpose. Mr. Hawkins told us he did not ensure that his advances were indicated on the vouchers because he understood that when the vouchers were processed for payment, the advance would automatically be applied to his reimbursement amount. When the vouchers were paid, the advances were, in fact, applied. While Mr. Hawkins' omission of his travel advances may be an honest mistake, given the other problems we noted with his vouchers, we question his intent here.

Allegation 2: Mr. Hawkins attempted to pressure a subordinate to inappropriately approve the expenditure of appropriated funds for an employee picnic.

We substantiated that Mr. Hawkins attempted to pressure a subordinate to inappropriately use funds available for an employee awards ceremony, and other appropriated funds, to pay for a September 1997 employee picnic. Appropriated funds generally cannot be used to purchase refreshments for employees. However, under the Federal Incentive Awards Program, light refreshments may be provided at ceremonies where incentive awards are given. Mr. Clay wanted the picnic for both East Campus and West Campus employees to encourage cohesiveness between the two facilities. He appointed a committee to plan the event and asked Mr. Hawkins to oversee those plans.

According to e-mail messages, on July 31, 1997 the committee chairman asked Mr. Hawkins for a budget so she could begin negotiating with prospective catering firms. Mr. Hawkins responded to the chairman, "we can use $8,500 from station funds as our Award Ceremony activity." He asked her to let him know if he needed to get additional funds.

On August 25, 1997, the chairman informed Mr. Hawkins that her cost estimate for the picnic was $8,400, plus $400 for invitations. The estimate was based on an attendance of 500 people (employees and family members), and included the purchase of food and

entertainment. The chairman specified to Mr. Hawkins what food would be served and what entertainment was planned. At that time, the committee chairman asked Mr. Hawkins if he planned to incorporate employee awards into the picnic. She told him that 1 hour was being allocated for that purpose, including a 10 to 15 minute opening address by the Director and 40 to 45 minutes for appreciation, "whatever that may be." In his response on August 26, Mr. Hawkins approved the plan developed by the committee and told the chairman, "all we have to do is state in the invitation that the picnic is our all employee awards ceremony." The former Chief, ***(b)(6)***, Service at the West Campus told us he discussed the picnic plans with Mr. Hawkins and told him that only "finger foods" could be served at an awards ceremony.

As the date of the planned picnic approached, the estimated attendance grew. On September 22, 1997 (less than a week before the picnic) the vendor selected to cater the event prepared cost figures based on an attendance of 1,866 people. The caterer's price was $24,609, including $13,062 for food and $11,547 for entertainment. The vendor then faxed a contract with the price, and the fact that it included an entertainment package, clearly stated on it to the West Campus. The contract was delivered to Mr. Hawkins and he signed it. The former Chief, ***(b)(6)***, Service at the West Campus told us that when his office was asked to prepare a purchase order, Mr. Hawkins told him the purchase should be paid from appropriated funds. The former Chief told Mr. Hawkins he could not do so, on the basis that spending appropriated funds for a picnic was a violation of regulations.

Despite repeatedly being informed that he could not spend appropriated funds on the employee picnic, Mr. Hawkins continued to pursue the matter. He proposed reducing the cost of the picnic by eliminating the entertainment, leaving $13,062 for food, but the former Chief, ***(b)(6)***, Service again told Mr. Hawkins he could not issue a purchase order for the food because to do so was still a misuse of appropriated funds. The former Chief told us Mr. Hawkins continued to insist that he prepare a purchase order to pay for the picnic. The former Chief eventually sought advice from the VISN's Acquisition and Support Service Center. As a result of this contact, VISN officials became aware of the situation and intervened. The VISN Chief Financial Officer told Mr. Hawkins it might not be appropriate to use appropriated funds for the picnic. On September 25, the picnic was cancelled.

Mr. Hawkins told us that when he signed the contract, he did so without regard to where the funds were coming from or what was being purchased. However, based on the events as discussed above, we concluded that Mr. Hawkins intended to inappropriately use appropriated funds, including $8,500 available for an incentive awards ceremony, to pay for food and entertainment for the picnic, and attempted to pressure a subordinate to approve the expenditure.

Allegation 3: Mr. Hawkins violated nepotism laws by advocating the employment of his son.

We substantiated that Mr. Hawkins violated Federal nepotism laws by asking the Chief, · ***(b)(6)*** · · · · Service at the West Campus to hire his son as a · ***(b)(6)*** · · · · · · · · · · · · · · · Mr. Hawkins' action violated Federal laws restricting the employment of relatives of public officials and making such action a prohibited personnel practice.

The Chief, · ***(b)(6)*** · · · · Service, who was responsible for the hiring of Mr. Hawkins' son, testified that shortly after Mr. Hawkins assumed his responsibilities as Associate Director on May 29, 1997, the two of them, and other staff, had an introductory meeting. During this meeting, the Chief mentioned to Mr. Hawkins that he was having difficulty retaining staff at the West Campus · ***(b)(6)*** · · · · Service. The Chief testified that about a week or two later Mr. Hawkins asked if the Chief was still having such problems. When the Chief responded that he was, he said Mr. Hawkins told him "I have a son, why don't you put my son to work, … my son is available for a job, … he'll be glad to work." The Chief testified that on or about June 18, 1997, shortly after his conversation with Mr. Hawkins, the son handed him [the Chief] an application for employment, and that he later hired the son.

Based on our review of the relevant statute and enabling regulations, we concluded that Mr. Hawkins advocated the employment of his son in violation of 5 U.S.C. § 3110, which provides:

> A public official may not…advocate for appointment, employment, promotion, or advancement, in or to a civilian position in the agency in which he is serving or over which he exercises jurisdiction or control, any individual who is a relative of the public official. An individual may not be appointed, employed, promoted or advanced in or to a civilian position in an agency if such appointment, employment, promotion, or advancement has been advocated by a public official, serving in or exercising jurisdiction or control over the agency who is a relative of the individual.

In reaching our conclusion, we found that Mr. Hawkins met the statutory definition of a public official in that he was vested authority by law, rule, regulation or delegation, to appoint, employ, promote or advance, or to recommend individuals for appointment, employment, promotion or advancement, in connection with employment in the agency. [5 U.S.C. § 3110(a)(2)]. We also determined that his son met the statutory definition of a relative. [Id. par. (a)(3)]

Although the Chief testified that he was not pressured or coerced by Mr. Hawkins to hire his son, we concluded that coercion and/or pressure are not factors required for a finding that a public official violated the statute by advocating a relative for employment. Nevertheless, there was evidence that the Chief did feel pressure to hire Mr. Hawkins' son. The Chief testified that after receiving and reviewing the son's application, he [the Chief] directed his Associate Chief at the West Campus to fire an employee and, in her

place, hire Mr. Hawkins' son. The Associate Chief told us that he did not want to fire the employee because he thought she was a good performer. He said he therefore hired Mr. Hawkins' son in lieu of another individual who had applied and been selected for a position.

Mr. Hawkins told us that shortly after we began our review of this issue, he instructed his son to resign his position, and he did. In addition, the Chief testified in October 1997 that the individual who was previously denied the position was hired.

Allegation 4: Mr. Hawkins permitted staff to spend more than necessary on safety shoes.

We substantiated that a decision made by Mr. Hawkins allows Environmental Management Service staff at the West Campus to spend more than necessary on standard safety shoes. We were told that Environmental Management Service staff purchased their standard safety shoes from a contract source, at about $50 a pair. On occasion, more expensive shoes costing from $63 to $83 a pair were purchased from the contract source. However, one staff member who had a physical impairment, complained about the type of shoe being provided. Based on this one complaint, Mr. Hawkins decided that staff needing safety shoes could obtain them from a local retail establishment for a cost not to exceed $125. Mr. Hawkins told us he was not aware that the cost escalated so dramatically due to his decision. Because we reviewed this allegation shortly after Mr. Hawkins made his decision, we were unable to determine the extent to which staff are actually spending more on the purchase of shoes.

Allegation 5: Mr. Hawkins approved moving a refrigerator purchased with appropriated funds into the Director's suite.

We substantiated that Mr. Hawkins approved moving a refrigerator initially purchased for the East Campus Nursing Home into the staff lounge area of the Director's suite. The refrigerator was purchased with appropriated funds and, as such, should not have been used for the private benefit of the Director and his staff. Comptroller General decisions regarding the use of appropriated funds clearly indicate that the purchase of lunch facilities for use in other than an established cafeteria is authorized only in unusual circumstances, such as when employees must remain at their duty stations for 24-hour shifts. Mr. Hawkins acknowledged to us that he made the decision to move the refrigerator because it could not be used in the Nursing Home as originally intended. At our suggestion, management again moved the refrigerator, this time replacing an older model in the East Campus' Recreation Service for the use by veterans.

Allegation 6: Mr. Hawkins interfered with an OIG investigation.

We substantiated that Mr. Hawkins interfered with an OIG investigation. In July 1997, an OIG Office of Investigations agent took an employee's official personnel folder from the East Campus to use as evidence in a criminal investigation. East Campus staff

immediately notified Mr. Hawkins what had happened, and he directed the facility's police to detain the person who took the file. However, the OIG agent left the grounds before the police could find him. Mr. Hawkins told us that when he was informed someone took the employee's personnel folder, he was not told, and did not know, who took it. He said he was only concerned about the security of the folder, and that it was not until later that he learned it was an OIG agent involved. However, the East Campus' former Acting Chief, · ***(b)(6)*** · Service, who notified Mr. Hawkins of the incident immediately after it happened, told us she did inform Mr. Hawkins that the person who took the folder was an OIG representative.
In October 1997, Mr. Hawkins provided information to the Federal Public Defenders office, stating that the OIG agent did not have the right to take the folder. Mr. Hawkins' testimony was to be used in support of the employee involved in the criminal investigation.

Unsubstantiated allegation

We did not substantiate the following allegation against Mr. Hawkins:

- A complainant alleged that, at Mr. Hawkins' request, walkie-talkies were purchased for the East Campus on the open market when a contract source was available. We reviewed the purchase order, dated June 19, 1997 for the items in question, ten hand-held radio transmitters. The purchase was made from a contract provider.

Conclusion

Mr. Hawkins was reimbursed a total of $4,186.60 in excessive meal expenses for his move to VAMC Saginaw, and later to the CAVHCS, which he claimed on his travel vouchers while in temporary quarters. The expenses were excessive because they were not reasonable. He also was reimbursed expenses for laundry when he had a clothes washer and dryer in his temporary quarters, failed to ensure that his travel advances were properly noted on his vouchers, and made duplicate claims for reimbursement of his meals and incidental expenses on 2 days.

We found Mr. Hawkins' personal conduct to be questionable when he violated Federal nepotism laws by asking the Chief, · ***(b)(6)*** · · · · Service at the West Campus to hire his son as a · ***(b)(6)*** · · · · · · · · · · · · · · · Mr. Hawkins' action was also a prohibited personnel practice.

We found Mr. Hawkins' attempt to pressure an employee to inappropriately use funds available for an employee awards ceremony, and other appropriated funds, to pay for an employee picnic, to be mismanagement. He made a decision allowing Environmental Management Service staff at the West Campus to spend more than necessary on standard safety shoes. Finally, he inappropriately approved moving a refrigerator initially purchased for the East Campus Nursing Home into the staff lounge area of the Director's suite and interfered with an OIG investigation.

Recommendation 2

The Director, CAVHCS, should:

a) Issue a bill of collection to Mr. Hawkins for excess meal reimbursements, unnecessary laundry expenses, and for a duplicate claim he received funds for during his permanent change of duty station moves to Saginaw, Michigan and CAVHCS (questionable costs totaled $4,388.90).

b) Take appropriate administrative action against Mr. Hawkins for violating the Federal nepotism law [5 U.S.C. § 3110] and committing a prohibited personnel practice [5 U.S.C. § 2302(b)(7)] by advocating his son for employment, making excessive claims on his travel vouchers, and attempting to pressure a subordinate to inappropriately spend appropriated funds for an employee picnic.

c) Issue a bill of collection to Mr. Hawkins' son to recoup salary paid to him during his employment.

d) Instruct Mr. Hawkins to coordinate his purchasing decisions with staff knowledgeable about economic sources of supply before he decides on a purchase strategy.

e) Remind Mr. Hawkins that equipment purchased with appropriated funds may generally not be used for the exclusive benefit of staff.

f) Take appropriate administrative action against Mr. Hawkins for interfering with an OIG review.

VHA Comments

The Chief Network Officer concurred in part with recommendation 2.a. and recommendation 2.b. as it pertained to taking administrative action against the Associate Director for making excessive claims on his travel vouchers. The Chief Network Officer noted that VHA would request that Austin conduct a complete audit of Mr. Hawkins' travel claims and would issue a bill of collection, if appropriate, based on that audit. The Chief Network Officer concurred with the remaining elements of recommendation 2.b. and with recommendations 2.c., 2.e., and 2.f. He noted that VHA considered Mr. Hawkins' violation of the nepotism statute to be a de minimis technical violation. Further, regarding recommendation 2.e., the Chief Network Officer noted that, in some instances, a refrigerator may properly be purchased for a workplace.

The Chief Network Officer did not concur with recommendation 2.d., noting that VHA believed Mr. Hawkins was aware of the process of requesting service chief input, and that every VA manager should be afforded the flexibility to use independent judgement when seeking and using advice from service chiefs. The Chief Network Officer stated that Mr. Hawkins' judgement in the instance of the shoe purchase would be weighed

along with other instances, including the employee picnic and contracting with an 8a contractor, when deciding what appropriate administrative action to propose. The Chief Network Officer's complete comments are in Appendix B.

OIG Response

Regarding recommendation 2.a., while we do not see a need for an additional audit by Austin finance staff, we do not object to the review being performed. Our finding and recommendation was based on a review of pertinent rules and regulations, a determination by the Chief of VA's Travel Policy Division, and a recent ruling by the General Services Board of Contract Appeals.

VHA took the position that VA policy allows an employee to be reimbursed actual subsistence expense while in temporary quarters if the amounts claimed over the 30-day period were reasonable, and that the total amount claimed by Mr. Hawkins did not exceed what VHA considered reasonable. VHA also noted that the total amount claimed did not exceed the total amount authorized for lodging, meals, and incidental expenses.

Our position is that VA policy allowing employees to claim actual expenses pertains only to lodging, and that the amount authorized for meals and incidental expenses cannot be exceeded, even if the total amount of the voucher is within total authorized for lodging, meals and incidental expenses. In support, we cite a February 1998 General Services Board of Contract Appeals (GSBCA) ruling (Matter of Arthur T. O'Conner, GSBCA, Case # 14422-RELO) that employees are entitled only to the authorized daily allowance for meals and incidental expenses. In this case, a Federal Government employee claimed reimbursement for meals and incidental expenses in excess of the amount authorized for meals and incidentals, while in temporary quarters. The employee's agency limited its reimbursement to the authorized rate and the employee appealed the decision. In affirming the agency's decision not to reimburse Mr. O'Conner in excess of the standard per diem rate, the General Services Board of Contract Appeals Judge ruled that regulations in place in 1996 provided that the "maximum" daily rate an agency can reimburse an employee for meals and incidentals in the first 30 days in temporary quarters located in the continental United States is the standard per diem rate paid to travelers in the continental United States, and that the maximum daily rate that an agency can reimburse an employee for succeeding days is three-fourths of the standard per diem rate. The Judge ruled that the agency's decision to reimburse the employee at the amount authorized for meals and incidentals was appropriate.

As indicated in our report, Mr. Hawkins' claim for reimbursement exceeded the amount he was authorized for meals and incidental expenses with respect to his permanent change of station (PCS) move to Saginaw, MI, and in a subsequent PCS move to Montgomery, AL. A review of Mr. Hawkins' travel vouchers for his PCS to Saginaw disclosed that his authorized amount for meals and incidental expenses totaled $1,833, yet he claimed $3,224, which was $1,391 more than he was entitled to for meals and incidental expenses. Concerning Mr. Hawkins' PCS to Montgomery, Mr. Hawkins and his family were authorized $4,091.25 for meals and incidental expenses. Mr. Hawkins claimed

$6,886.85, or $2,795.60 more than he was authorized. Based on pertinent travel regulations and on the GSBCA decision, Mr. Hawkins was inappropriately reimbursed a total of $4,186.60 for these two PCS moves.

We maintain that the daily allowance for meals and incidental expenses authorized for Mr. Hawkins and his family was more than reasonable, especially considering VA paid an extra $100 a month for Mr. Hawkins and his family to have access to a fully equipped kitchen. Furthermore, as we stated in our report, the Chief, Travel Policy Division in VA Central Office concluded that the expenses Mr. Hawkins' claimed for meals, in excess of the authorized rate, were not reasonable. Since the Chief, Travel Policy Division has the authority in VA for travel policy, we deferred to her judgment on the matter of reasonableness.

In addition to the excessive meal claims, we believe Austin finance staff should be aware of our finding that Mr. Hawkins inappropriately claimed $157.30 for coin-operated laundry expenses even though his temporary quarters was equipped with a washer and dryer. Even if his quarters were not equipped with a washer and dryer, all laundry, cleaning, and pressing of clothing are expenses that are covered within the per diem amount authorized for incidental expenses (Federal Travel Regulation, Section 301-7 - Per Diem Allowances). In response to VHA's comments, we reexamined these regulations and Mr. Hawkins' PCS vouchers to Montgomery. In doing so, we discovered that Mr. Hawkins claimed $601 for dry cleaning in addition to his claim for meals and incidentals. Since the Federal Travel Regulations are clear that all laundry and dry cleaning expenses are already covered by the per diem, Mr. Hawkins was not entitled to reimbursement for his coin-operated laundry and dry cleaning expenses, totaling $758.30.

Adjusting for the bill of collection for $80 already issued to Mr. Hawkins for his overpayment due to his duplicate reimbursement for TDY travel and Temporary Quarters, we recommend that VHA issue Mr. Hawkins a bill of collection for $4,186.60 in excess meal expenses and $758.30 in unallowable laundry and dry cleaning expenses, for a total of $4,944.90. To ensure Austin finance staff adequately address the concerns raised in this report, we will provide them with all relative travel documents and related working papers. We will follow up to ensure appropriate corrective actions are taken to resolve our concerns.

Regarding recommendation 2.b., we do not agree with VHA's unsupported characterization that Mr. Hawkins' violation of the nepotism statue was unintentional and a de minimis technical violation. VHA cites no evidence, law, regulation, or policy to show that intent is a relevant consideration or that there are gradations to violations of 5 U.S.C. §3110, i.e., de minimis and technical. Furthermore, our finding that there was a violation is based on the fact that the · ***(b)(6)*** · · · · Service Manager decided to withdraw an offer of employment to another person in order to hire the Associate Director's son. This action was in response to discussions between the Associate Director and the · ***(b)(6)*** · · · · Service Manager concerning the availability of Mr. Hawkins' son for employment. Despite the · ***(b)(6)*** · · · · Service Manager's inference that he did not feel pressured by Mr. Hawkins to hire his son, we believe his actions dictated

otherwise. After Mr. Hawkins was confronted with the allegation of nepotism by the OIG, he removed his son from employment, and the · ***(b)(6)*** · · · · Service Manager rehired the original selectee for the position.

The Chief Network Officer's comments met the intent of the recommendation 2.c. and we will follow up on the proposed collection action. We agree with VHA's position and planned action with respect to resolving recommendation 2.d. Regarding recommendation 2.e., the Chief Network Officer commented that a refrigerator might, in some instances, properly be purchased for a workplace. The situation we discuss above, however, is not one of those instances. VHA's comments to recommendation 2.f. are responsive and we will follow up to ensure appropriate administrative action is taken.

Issue 3: Other Senior Management Actions

Managers are often faced with acting as an arbitrator between subordinate employees and their supervisors or managers. In resolving these types of conflicts, managers must make fair, impartial and objective determinations based on fact. This can only be accomplished if the manager gives both sides the opportunity to be heard. This was not fully accomplished at the CAVHCS.

Union complaints

Commencing in November 1996, AFGE Local 503, the bargaining unit representative for Montgomery, had a series of meetings with Mr. Clay to discuss problems the union perceived at the West Campus. Local 503's complaints included racial issues of mistreatment of African-American employees by Caucasian managers, and lack of non-Caucasian representation on the management side of the partnership council. According to the union, African-American employees were consistently given harsher sanctions than were Caucasian employees for identical infractions. It was also alleged that African-American employees were consistently terminated and not promoted as often as Caucasian employees. ***(b)(6)***, ***(b)(6)*** Chief, was also described by the union as treating employees like "slaves." Mr. Clay made no specific commitment at these meetings to address these problems.

AFGE Local 110 also had made complaints about specific Tuskegee managers to Mr. Clay. Complaints were directed against ***(b)(6)*** Chief ***(b)(6)*** and ***(b)(6)*** Chief ***(b)(6)*** for what the union perceived as hostility to the union. No specific actions were taken or promised by Mr. Clay as to these complaints.

On January 7, 1997, the second business day after former Montgomery Director Mr. Rowan had retired, and Mr. Clay assumed acting directorship over the West Campus, Mr. Clay met with ***(b)(6)***, ***(b)(6)***, ***(b)(6)***, ***(b)(6)***, and ***(b)(6)***. This was Mr. Clay's first meeting with the managers at the West Campus. He told them that the Local 503 had complained about their "clique" which ran the hospital, came and went when they pleased, and took long lunch hours without charge to leave. Mr. Clay made no attempt to discuss the issues with these managers nor did he make any effort to determine whether the allegations were factually correct. Instead Mr. Clay informed the managers that this would have to stop and that there would be change. Because of Mr. Clay's attitude and the fact that he conducted the meeting in an accusatory manner, the managers felt threatened and that Mr. Clay was unfairly siding with the union just to improve relations. In our view, Mr. Clay's response to non-specific union allegations and complaints was inappropriate, demonstrated a bias against the managers at the West Campus, and created a divisive atmosphere between him and his managers.

Similar divisive actions by management continued after the arrival of the new CAVHCS Associate Director, Mr. John Hawkins, in May 1997. In response to complaints from the

unions, during August and September 1997, Mr. Hawkins had meetings with · ***(b)(6)*** Service (· ***(b)(6)***) staff and · ***(b)(6)*** Service staff about problems in the services. At these meetings, Mr. Hawkins heard complaints directed against · ***(b)(6)*** and · ***(b)(6)***, the Chiefs of the Services.

Mr. Hawkins' meetings with the employees in both services had similar themes. At the West Campus, · ***(b)(6)*** employees expressed concern that their supervisor · ***(b)(6)***, passed them over for promotions, treated them unfairly, or retaliated against them. Mr. Hawkins met separately with · ***(b)(6)*** after this meeting. He gave · ***(b)(6)*** a list of the unions' complaints and asked for a response. He later met with · ***(b)(6)*** and his staff. The meeting was described by · ***(b)(6)*** and other members of his staff as a free-for-all for the union and an attack on · ***(b)(6)***. The witnesses stated that Mr. Hawkins showed no support for · ***(b)(6)***.

Mr. Hawkins had a similar meeting with the · ***(b)(6)*** Service employees on September 3, 1997, and they expressed concern that their Chief, · ***(b)(6)***, and first line supervisor, · ***(b)(6)***, treated them unfairly. The employees major complaint stemmed from not obtaining upgraded positions, but staff also complained of unfair treatment and retaliation by their supervisors. Mr. Hawkins met separately with · ***(b)(6)*** and · ***(b)(6)***, who testified that Mr. Hawkins did not want to hear their side of the complaints, or want to discuss the performance problems in the service.

One supervisor believed that Mr. Hawkins was trying to appease the union at their expense. Mr. Hawkins said he met with the supervisors and employees in · ***(b)(6)*** Service on October 3, 1997. The supervisors believed Mr. Hawkins took sides with the union without sufficiently investigating the sources of the complaints, or whether he was receiving negative input from employees who had serious performance problems which the supervisors believed was the case. As with the meeting Mr. Clay had with the West Campus managers on January 7, 1997, the meetings Mr. Hawkins had with · ***(b)(6)*** and · ***(b)(6)*** Service created divisiveness, lack of trust and negatively impacted morale. Managers have a responsibility to take complaints seriously and try to resolve problems. However, other than allegations, we were not provided any evidence by the unions or management to support the complaints.

Removing Computer Access

We also found that Mr. Clay and Mr. Hawkins made arbitrary and capricious decisions that affected management and support staff unfairly. On or about December 9, 1997, nine employees (seven incumbents who were not selected for the positions, the Chief of · ***(b)(6)*** Service, and the management assistant for · ***(b)(6)***) suddenly had their computer access denied which they testified impeded their ability to do their jobs. The action was taken by the Chief · ***(b)(6)*** at the request of Mr. Hawkins.

Mr. Clay testified that he was aware that this was being done and that he agreed with Mr. Hawkins' decision. He testified that the action was taken because he thought that

someone was trying to "read or pick up things that [he] was transmitting or receiving." He further stated that on two occasions it was thought that someone had gotten into his office on the weekend and manipulated Mr. Hawkins' secretary's computer and that information from his office "had been getting out." He was, however, unable to provide specific examples to support his statement other than expressing concern that e-mail information had ended up in a Congressman's office.

Mr. Hawkins testified that he took the action to have the nine employees' computer access denied because he had found out from the union that information on employees, e.g., bank accounts, transfer data, etc., was being released from one fiscal office to the other. He further stated that his action was based on the fact that the union told him that "the ***(b)(6)*** may try to disrupt the computer system, along with the ***(b)(6)***, between FMS and IFCAP." So, after he checked with the new Chief ***(b)(6)***, ***(b)(6)***, and the Chief, ***(b)(6)***, ***(b)(6)***, he asked that the people not selected and ***(b)(6)***, ***(b)(6)***, ***(b)(6)*** Service, have their access taken away. Mr. Hawkins and Mr. Clay acted on rumor and speculation; they made no effort to discuss the matter with the nine employees involved nor did they have the basic courtesy of informing them that the action was going to be taken; and, they failed to make any effort to determine whether these employees needed access to these systems to do their jobs. This is not evidence of good management practice.

Conclusion

There is an atmosphere at CAVHCS of distrust and divisiveness between top management and certain managers. We concluded that the current atmosphere is in part due to the decisions made by Mr. Clay and Mr. Hawkins. Managers believed that top management did not adequately review allegations brought to their attention by the union to determine the validity of the complaints. Also, managers were dismayed with top management and actions to capriciously remove their computer access without evidence of any wrongdoing and without considering the consequences on job performance.

Recommendation 3

The Director, VISN 7 should:

a. Increase the VISN's involvement in the conflict between top management and the managers discussed during this review with the objective of ensuring all staff are working effectively together towards VA goals.

b. Ensure that any computer accesses that were denied are not interfering with the job performances of any of the affected managers.

VHA Comments

The Chief Network Officer concurred with the above recommendations, noting numerous actions taken by the VISN to ensure all staff work together. He stated that VISN staff will continue to lend support to CAVHCS as it transitions through the changes that will be brought about by the integration and the OIG review. The Chief Network Officer also provided assurances that the affected managers have been provided computer access appropriate to their new work assignments. His complete comments are in Appendix B.

OIG Response

The Chief Network Officer's comments with respect to recommendations 3.a. and 3.b. are responsive and we consider the issues resolved.

PART III

STAFFING OF CAVHCS MANAGER POSITIONS

Issue: 1: Prohibited Personnel Practices

Several complainants alleged that they were either discriminated against on the basis of race and/or age, or retaliated against for either providing information to the Congress, to the Office of Inspector General (OIG) or to the General Accounting Office (GAO). The complainants were employees at CAVHCS who were not selected, or not given the opportunity to compete, for the integrated service chief positions that were the result of the integration of the East and West Campuses.

Title 5, United States Code, §2302(b)(8) prohibits retaliation against employees who make disclosures that are protected under the Whistleblower Protection Act. Similarly, §2302(b)(9) prohibits retaliation against employees who engage in certain protected activities such as filing grievances or EEO complaints and cooperating with or disclosing information to the OIG. We substantiated the allegations that there was retaliation for whistleblowing, in violation of 5 USC §2302(b)(8) and/or for cooperating with the OIG, in violation of §2302(b)(9), in the case of five of the complainants.

Our review also identified evidence that supports allegations of a possible pattern of preferential treatment based on race. We brought this evidence to the attention of the VA Office of Resolution Management (ORM). Because an ORM employee was reviewing a number of EEO cases related to various personnel actions at CAVHCS, they agreed to expand the scope of their review to include whether there is a systemic problem of preferential treatment. We provided ORM access to all of the relevant EEO information we obtained during our review.

Complainants Met Their Burden of Proof

Employees who allege retaliation in violation of §2302(b)(8) and (b)(9), have the initial burden of proving by a preponderance of the evidence that they engaged in a protected activity and that this was a contributing factor in management's decision to take, or not take, a specific personnel action. The contributing factor test can be met by showing a relationship between management's knowledge of the protected activity or that management suspected that the employee engaged in a protected activity, and the timing of the personnel action.

We concluded that there is sufficient evidence to show that each of the complainants either engaged in a protected activity or was suspected by management of having been involved in a protected activity. In addition to the fact that the protected activities occurred at or around the time of the selections, management's negative reaction to the protected activities, which included efforts to dissuade employees from participating in the OIG investigations, further supports our conclusion.

Management Cannot Meet Its Burden of Proof that the Actions Were Not In Retaliation for Engaging in Protected Activities

Once the employees have met their initial burden, the burden shifts to management to prove by clear and convincing evidence that the same action would have been taken absent the protected activity. Factors considered in evaluating whether management has met its burden of proof are:

- the reasonableness of management's decision(s);
- whether there was motive to retaliate; and,
- how management treats other employees who are not involved in protected activities.

Based on our review of all these factors, we concluded that management couldn't meet its burden of proof. Management's decisions were found not to be reasonable because they did not develop or adhere to a plan that would meet their stated goals and objectives for the integration and they failed to conduct a fair and impartial selection process as required by the merit systems promotion principles.

Evidence of a motive to retaliate is shown in the statements made by Mr. Clay and Mr. Hawkins both to the employees in CAVHCS and to the OIG. These statements demonstrated a negative reaction towards the oversight reviews being conducted and, in particular, towards the employees who were suspected of being responsible for the reviews.

We reviewed other selections made by Mr. Clay and Mr. Hawkins during the integration and found that employees who were not involved in protected activities, or not suspected of being involved, were treated differently from the complainants and others suspected of being responsible for the reviews.

Management's Decisions Were Not Reasonable

Management did not develop and adhere to a plan that would meet the stated goals and objectives of the integration. On November 12, 1996, shortly after the decision to integrate the Montgomery and Tuskegee facilities was made, the Directors, Mr. Rowan and Mr. Clay, issued a joint memorandum to all service chiefs and supervisors at both facilities concerning the requirements for the recruitment for vacancies. The memorandum stated that, in addition to filling critical positions in a timely manner, "[w]e have a responsibility to ensure that current qualified employees are provided priority consideration for vacancies. With the consolidation of our budgets, there will be limited resources available to effect outside hires and promotions."

This memorandum is consistent with testimony from employees who attribute similar statements to Mr. Clay at an integration orientation session at the Tuskegee Institute

Conference Center in October 1996 to the effect that outside recruitment for combined positions would only occur if neither incumbent was qualified. Mr. Clay has denied making this statement, telling us that he always stated that the facility would recruit the best-qualified candidates. He added that he explicitly did not rule out qualified local candidates. In the absence of any tape, transcript, or minutes of the session, we were unable to verify exactly what Mr. Clay said in the October meeting. However, this is irrelevant because whether the goal or objective was to make selections that would be cost-effective or to select the best qualified candidates for the position, we found that these objectives were seldom met.

Although there were well-qualified incumbents in CAVHCS to fill the combined service chief positions, on or about May 1997, Mr. Clay made a decision to open some but not all of the service chief positions for VHA nationwide competition. Our review of the processes used for the selection of these positions showed a lack of consistency which management failed to justify. This finding is supported by the testimony of ***(b)(6)***, ***(b)(6)***, West Campus, that Mr. Clay did not follow a prescribed plan for the integrated positions. ***(b)(6)*** testified: "Each week, you didn't know what ball game you were attending. One week, everything had to go nationwide. Another week, we'll only do between the campuses...It was just like the 'selection du jour' of the week...how we were going to handle it."

In addition, management did not have a plan with respect to what would happen to the incumbents who were not selected. The applicants selected for six of the nine service chief positions were outside candidates even though there were one or more well-qualified incumbents.

After the selections there were two or more supervisors encumbering the same position in ***(b)(6)***, ***(b)(6)***, ***(b)(6)***, ***(b)(6)*** and ***(b)(6)***. The HRM personnel specialists who reviewed the technical aspects of these selections identified this as a regulatory violation, and correction of the situation will result in the implementation of Reduction-in-Force (RIF) regulations which could result in the displacement of at least three of the five selectees.[1] This lack of planning resulted in increased salary costs as well as significant costs associated with the permanent change of station which defeated one of the stated objectives of the integration which was cost savings.

The need to resort to RIFs could have been avoided had CAVHCS management heeded the advice they received from their own Chief, HRM and the Chief, HRM in Decatur, GA. who handled the announcements for these positions. Mr. Clay and the ***(b)(6)*** Chief, ***(b)(6)***, exchanged a series of memoranda concerning the announcement of the combined service chief positions in April and May of 1997. Mr. Clay indicated he was interested in considering alternatives to open recruitment of the combined service chief positions during a mid-April 1997 meeting.

[1] One of the incumbents, ***(b)(6)***, Chief of ***(b)(6)*** at the Montgomery Campus and the Acting Chief of ***(b)(6)*** for CAVHCS recently transferred to the VAMC in ***(b)(6)***, avoiding an additional RIF issue that would have been present had he stayed at CAVHCS.

The HRM representatives advised them that the use of retention standing of the incumbents of the positions would be the quickest, fairest way to accommodate the staffing of these positions. ***(b)(6)*** April 30, 1997, memorandum to Mr. Clay confirms this advice, and offers an alternative to open recruitment in which the service chief positions would be filled with incumbents based on retention standing under the RIF rules, and that nationwide announcement and competitive application procedures would be used to fill positions where there was no incumbent.

(b)(6) further stated that this method would not only reduce staffing adjustments, but would also reduce the possibility that a non-selected incumbent could "bump" a selectee through the exercise of RIF reassignment rights. ***(b)(6)*** stated: "No matter what course of action is chosen, it must be remembered that if an encumbered position is to be abolished that the provisions of 5 CFR 351 apply. Part 351 specifically deals with Reduction-in-Force." Mr. Clay disregarded this advise and announced the following positions VHA-wide for the purpose of obtaining a broader consideration: ***(b)(6)*** (***(b)(6)***, formerly ***(b)(6)*** [***(b)(6)***]), ***(b)(6)***, ***(b)(6)*** (***(b)(6)***, formerly Chief, ***(b)(6)***), and several other service manager positions. Each of the positions had one or more incumbents at the time of this action.

(b)(6) responded to Mr. Clay setting forth his concerns about Mr. Clay's decision to announce the service chief positions. In particular, ***(b)(6)*** pointed out that the ***(b)(6)***, ***(b)(6)***, and ***(b)(6)*** positions all were encumbered at the same job series and grade. A potential similar problem also could result from the occupational series of the ***(b)(6)*** position. ***(b)(6)*** recommended that these conflicts be resolved through the RIF retention standing procedures he had previously described.

Mr. Clay told us that ***(b)(6)*** was providing incorrect information and resisting his efforts at integration. According to Mr. Clay, this was the reason Mr. Bill Lamm, Chief, Human Resources Management (HRM), Atlanta VAMC, was consulted on the staffing procedures. Mr. Lamm's input was consistent with ***(b)(6)*** advice.

Mr. Clay told us that he did not think the RIF rules would apply because CAVHCS was not planning to run a RIF in the integration process. On August 11, 1997, Mr. Clay gave the go-ahead to announce the combined service chief positions. Mr. Clay e-mailed Mr. Lamm to announce the positions VA-wide. Mr. Lamm explained to Mr. Clay the consequences of not selecting an incumbent that would "bump" a selectee under the RIF procedures.

Believing that Mr. Clay did not fully understand what he had explained, Mr. Lamm also met with ***(b)(6)***, ***(b)(6)***; and ***(b)(6)***, ***(b)(6)*** to explain the RIF consequences. Mr. Lamm testified that he provided essentially the same information that ***(b)(6)*** had provided in April and May.

Mr. Lamm hand-carried the application packages to Mr. Clay in Tuskegee at the beginning of October 1997. Mr. Lamm had his staff annotate the candidates that were "safe" selections, from a RIF standpoint, with an asterisk. Out of ten positions, Mr. Hawkins and Mr. Clay only selected three individuals who had been identified as safe selections.

Positions Identified By HRM Atlanta Personnel as "Safe Selections" [2]

Chief Position	Safe Selection	Incumbent	Selectee	Selectee's Station
(b)(6)	***(b)(6)*** ***(b)(6)*** [3]	Yes	***(b)(6)***	Saginaw
(b)(6)	***(b)(6)***	Yes	***(b)(6)***	Detroit/Saginaw
(b)(6)	***(b)(6)***	Yes	***(b)(6)***	Saginaw
(b)(6)	***(b)(6)*** [4] ***(b)(6)***	Yes No	Cancelled	East Campus
(b)(6)	***(b)(6)*** [5]	Yes	Cancelled	West Campus
(b)(6)	***(b)(6)***	Yes	***(b)(6)***	West Campus
(b)(6)	***(b)(6)***	Yes	***(b)(6)***	N. Chicago
(b)(6)	***(b)(6)*** ***(b)(6)*** ***(b)(6)***	Yes No No	***(b)(6)***	Ann Arbor
(b)(6)	***(b)(6)***	Yes	***(b)(6)***	West Campus
(b)(6)	***(b)(6)*** ***(b)(6)*** ***(b)(6)***	Yes No No	***(b)(6)***	Saginaw

Mr. Clay either did not understand the advice of the personnel experts who tried to inform him regarding the problems he would face if incumbents were not selected, or he decided to disregard it because he had already decided that no one was going to be subject to a RIF. Either way, Mr. Clay and Mr. Hawkins did not have the authority to disregard the RIF rights of employees in this selection process.

At the time of our review, which was several months after the selections were made, there was still no organized plan for what to do with the non-selected incumbents and their role in CAVHCS was unclear. Some of the incumbents testified that they had little or no work to do. This was confirmed through our interviews with Mr. Clay,

[2] The three safe selections were ***(b)(6)*** [reassignment to new position description], ***(b)(6)*** , and ***(b)(6)*** .

[3] Although not an incumbent, ***(b)(6)*** was employed at CAVHCS.

[4] ***(b)(6)*** was reassigned to a new position after the announcement was cancelled but without announcing the new position.

[5] Mr. Hawkins created a new position, Chief, ***(b)(6)*** Service that was not announced, and reassigned ***(b)(6)*** to the position.

Mr. Hawkins, the new service chiefs, and the HRM team that assisted us in the review. The HRM technical review is discussed in more detail beginning on page 71.

The selection process violated merit system promotion principles.

Title 5, United States Code, § 2301(b)(1) provides that:

> Recruitment should be from qualified individuals from appropriate sources in an endeavor to achieve a work force from all segments of society, and selection and advancement should be determined solely on the basis of relative ability, knowledge, and skills, after fair and open competition which assures that all receive equal opportunity.

We reviewed the selection process, including the work of a rating and ranking panel, and concluded that the process did not always result in selections based on relative ability, knowledge and skills; nor did it evidence fair competition that assured that all received equal opportunity. The selection process was biased and unfair to the majority of the incumbent applicants, particularly the complainants, and demonstrated a bias in favor of applicants that Mr. Hawkins had worked with previously.

About the time Mr. Hawkins received the certificates from VAMC Atlanta, he assembled a panel to evaluate the applicants for the administrative service chief positions. He made the decision to assemble this group even though a merit promotion panel was not required for most of the positions because of the number of applicants that applied. The panel was to identify the top three candidates for each position from which Mr. Hawkins was to make his selection. The panel consisted of five members each of whom had one vote: ***(b)(6)***, ***(b)(6)***, ***(b)(6)***, ***(b)(6)***, ***(b)(6)***, Chief ***(b)(6)***, ***(b)(6)***, ***(b)(6)*** AFGE Local 110 (East Campus), and ***(b)(6)***, ***(b)(6)*** of AFGE 503 (West Campus). In addition, the unions were allowed to bring their vice-presidents and one other union representative who could not vote but otherwise fully participated in the process.

We found that neither Mr. Clay nor Mr. Hawkins identified or developed any specific or quantifiable criteria for the selection of these positions. When interviewed, Mr. Hawkins indicated that selection criteria were unnecessary. Because there were no standards or criteria for selection, the panel developed its own, a three-component scoring system for each candidate. The interview and qualification rating factors were each valued at 5 points. The most recent performance appraisal was worth 3 points for an outstanding, 2 for a highly successful and 1 for a fully successful. The maximum score for each candidate from each of the five panel members was 13 points with a possible total of 65 points from the panel as a whole.

The scoring process did not seem equitable. For example, the interviews, all done by telephone, were worth 25 of the possible 65 points and ranked equally with the

performance evaluation of the qualification rating factors. We also found that the interview questions were very basic and did not relate to the subject matter of the position for which the person was applying. With respect to the qualification rating factors, we found that some applicants did not have or did not complete them, yet this was not reflected in their scores.

In most cases, ***(b)(6)*** asked all but three of the questions. These three questions were asked by the union and concerned whether the candidate intended to abide by the Master Agreement, what the candidate thought of labor-management partnership, and whether the candidate had been the subject of any EEO complaints, grievances or union complaints and, if so, what was the result.

Some of the incumbents complained about the role of the unions in the selection process. We concluded that it was inappropriate to include the unions in the manner in which it was done in this case. The issue of partnership with the union was raised as one of the reasons the unions were included on the panel.

We reviewed the partnership agreement and found that including the union in a selection panel such as this was not mandated by any partnership or other management-labor agreement. With the exception of the issue of giving the union access to information protected under the Privacy Act, 5 U.S.C. §552a, there is no statutory impediment to having the union participate in the selection process in some circumstances. Involvement of the union is positive from the perspective of partnership. However, it was poor judgement by the facility's top managers to put union members on the panel when there was considerable, and known, animosity by the union towards incumbent managers and others who applied for the announced positions.

Mr. Melvin S. Weinstein, National Labor Relations Officer, VA's highest-ranking labor relations official, confirmed that inclusion of the union was an advanced state of labor-management partnership, but that partnership does not eliminate other applicable laws, rules, or regulations, including prohibitions against retaliation, discrimination, and management's responsibilities to manage. Mr. Weinstein stated that partnership brought the union into the review committee, but, once there, they were required to follow the rules and regulations that everyone else must follow.

We also discussed the issue of the union's access to Official Personnel Records with the Group IV Office of General Counsel (OGC). OGC advised us that they could not identify a routine use that would give one union ***(b)(6)***, who was not a Government employee, access to the Privacy Act protected records.

The bias of the local unions against many of the incumbent applicants is overwhelming. Shortly after the integration was approved and Mr. Clay was named Director for CAVHCS, the AFGE Local 503 at the West Campus had a series of meetings with Mr. Clay, the focus of which was complaints against the West Campus managers including the perception that Caucasian managers mistreated African-American employees based on race. Similar allegations were raised in a complaint letter, which

was sent by the union to Congressman Everett. Issues relating to this meeting and Mr. Clay's responses were discussed in Part II, Issue 3.

AFGE Local 110 expressed similar biases towards certain incumbents. When asked about the purpose of the interview question regarding prior EEO complaints, grievances, etc., the AFGE Local 110 panel member testified that the question was asked because the union was concerned about people coming in with a lot of "baggage" such as EEO cases and grievances. The witness went on to testify that people with "baggage" had been hired in the past which resulted in the union being "treated badly." The union representative further stated that some of those people were still there and were still giving the union trouble. In a follow-up interview, the same representative identified several incumbent applicants that the union had difficulty with and stated that she [the union representative] had personally filed complaints against one of the incumbents who was a former supervisor.

The union members who participated in the panel testified that their biases did not affect their rating of the applicants. We reviewed the rating documents and concluded that the biases did affect ratings. In some cases, hand written notes on documents in the selection files, such as "EEO problems," "Union Problems," evidenced the unions' concerns or complaints against certain applicants that could only be based on experiences with the applicants. The scores the unions gave the incumbents they identified as problems further reflect the unions' biases. The unions almost always scored these incumbents lower than other candidates. One non-union panel member testified that after the interviews the panel engaged in discussions about the candidates during which the union representatives made statements about candidates that the union did not like that were based on experience, not the information contained in the application files. Even if the unions' scores did not reflect their biases, which in our opinion they did, it was still inappropriate for Mr. Hawkins to place union representatives on a panel that had known biases against some of the applicants. At a minimum, it created the perception of bias and impartiality, which compromised the integrity of the selection process.

The panel's impartiality was further questioned by the fact that ***(b)(6)*** participated as the panel chairman. As the ***(b)(6)***, ***(b)(6)*** worked closely with the Director and Associate Director. As discussed below, both Mr. Clay and Mr. Hawkins had animosity towards many of the incumbents, particularly with those who were believed to be associated with allegations brought to the attention of Congressman Everett, which were the basis for several OIG investigations. These investigations were on going at the same time as the selection process. Several witnesses testified that ***(b)(6)*** approached them on behalf of the Director to obtain any information that they had given the OIG. ***(b)(6)***'s testimony that he was objective in his assessment of the applicants is not persuasive. ***(b)(6)***'s scores show that he scored incumbent applicants who Mr. Hawkins and/or Mr. Clay disliked lower than other candidates. There also is a notable difference in the scores ***(b)(6)*** gave the incumbents (lower) compared to the applicants from Saginaw whose files showed a previous connection with Mr. Hawkins.

We also determined that Mr. Hawkins inclusion of ***(b)(6)***, Chief ***(b)(6)***, on the panel was inappropriate with respect to the selection of the ***(b)(6)*** position because one of the incumbent applicants, ***(b)(6)***, had filed an EEO complaint regarding her selection for that position. At a minimum, it gave the appearance of a bias. We did not find Mr. Hawkins testimony persuasive that he was unaware of the EEO complaint because Mr. Clay had referred to the matter during his television interview in June 1997, and records show that the EEO investigator was conducting an on-site investigation at or around the same time the panel met to review the files. In addition, both Mr. Clay and Mr. Hawkins attended meetings with the EEO officer who certainly would have discussed the existence of this case.

The constitution of the panel appeared to be assembled to exclude anyone who would be favorable to any of the incumbent applicants. Mr. Clay testified that "One of the things we wanted to try to avoid is to put people in there that may have been close to the people that were being considered for the positions." But by including union members who had brought specific complaints to Mr. Clay and Mr. Hawkins about many of the incumbents, such as the West Campus "clique," the constitution of the panel had the effect of being stacked against incumbent applicants the union and others did not like.

Mr. Hawkins testified that he did not want ***(b)(6)*** on the panel "because there had been some issues with the selection process in the ***(b)(6)*** job." ***(b)(6)*** also was one of the targets of AFGE Local 503's complaints. The selection for the ***(b)(6)*** position occurred prior to Mr. Hawkins' appointment. When Mr. Hawkins was questioned further about his reasons for not wanting ***(b)(6)*** on the panel, he testified that it was his understanding that Mr. Clay had to give her the certificate twice and this was the reason for not wanting her on the panel. Since Mr. Hawkins had no direct knowledge regarding the facts and circumstances surrounding the ***(b)(6)*** selection process, his decision not to use ***(b)(6)*** on the selection panel was based on what he learned from Mr. Clay. We believe this decision supports our finding that Mr. Hawkins did not want a panel that might be favorable to certain incumbents.

With respect to the unions' question regarding prior EEO complaints and grievances, we found that at least one of the incumbent applicants was "marked down" because he refused to answer this question and indicated that the question was inappropriate. One of the applicants testified that he objected to the question because he thought that for the union to obtain this information was a violation of his right to privacy. We agree, particularly with respect to the AFGE Local 110 ***(b)(6)*** who was not a Government employee.

Once again, the process favored outside applicants because the unions and other panel members had knowledge of some of the complaints previously raised against the incumbents but not the outside applicants. We also believe that it is unreasonable to conclude that the union panel participants would be able to completely divorce their history of problems with the "clique" and other incumbents; a history so troublesome

that AFGE Local 503 raised it with Mr. Clay, Mr. Deal, and Congressman Everett, and the OIG.

It is an inappropriate management practice to include anyone in the selection process who has a bias, even a perceived bias, for or against any of the applicants. In addition, the fact that no one on the panel had subject matter expertise for any of the positions being reviewed and only one panel member had any managerial expertise, further supports our conclusion that the panel process was flawed and did not afford the incumbents and other applicants a fair and impartial review of their qualifications.[6]

During our initial interviews, neither Mr. Clay nor Mr. Hawkins would admit initially that they were the selecting officials for the consolidated service chief positions. Mr. Hawkins did, however, eventually concede that he made the selections, but only considered the top three candidates recommended by the panel. Mr. Clay denied responsibility for the selections in an e-mail that he sent to all CAVHCS employees on November 19, 1997, in which he stated that the "primary source for the selection method of the individuals for these positions was through use of a multidisciplinary panel. The Health Care System Director nor the Associate Director had any influence in the interviews, scorings, ratings, or rankings of the candidates." Mr. Clay's e-mail had the effect of placing the responsibility for the selections on the panel, not on CAVHCS management.

We concluded that neither Mr. Clay nor Mr. Hawkins took sufficient action to ensure that their stated goals and objectives for making these selections were met. Mr. Clay testified that it was his objective to hire the "best qualified" candidate for each position and that Mr. Hawkins told him that the best qualified candidate was selected, so he "didn't question it beyond that." Except for a general endorsement of the selections made by Mr. Hawkins, Mr. Clay did nothing to assure himself that the candidates selected were, in fact, the best qualified.

Mr. Clay's stated objective, to hire the best qualified, was not consistent with Mr. Hawkins' objective. When asked why the panel he assembled did not have subject matter experts or managerial experts, Mr. Hawkins testimony showed that he was more concerned with the union being comfortable with who was selected than he was with selecting a person who had the knowledge and skills needed to do the job.

We believe that Mr. Hawkins intentionally mislead both Mr. Clay and Mr. Deal regarding the process surrounding, and merits of, his selections. Mr. Hawkins prepared a selection memorandum for each position. With the exception of the names and other information relating to the applicants, the memoranda were the same. The memoranda contained a statement that "diversity and seniority considerations were fully addressed." The statement was not consistent with the panel members testimony. The panel members unanimously testified that they did not consider or discuss any diversity characteristics. The fact that the advice and counsel of two personnel officers

[6] While the argument may be made that some of the incumbents made the top three lists, it must be noted that in some cases the number of candidates made this unavoidable.

regarding the risk of possible RIFs was ignored, shows that seniority considerations were not addressed. When questioned about the inclusion of this statement in the memoranda, Mr. Hawkins testified that he took the statement from the Executive Resource Board for the Director and Associate Director positions. Mr. Hawkins did not provide us with any information to show that he considered either diversity or seniority in making the selections.

Mr. Hawkins further represented in his memoranda that he interviewed the top three candidates, when he did not interview anyone. Mr. Clay's testimony shows that he believed Mr. Hawkins' representation regarding the interviews when he approved Mr. Hawkins' selections. Mr. Deal stated that he performed a cursory review to satisfy himself that there was a process supporting the selections. Because Mr. Hawkins relied on an unqualified and biased panel and did nothing to ensure that the selections were based solely on relative ability, knowledge, and skill, or that the applicants received equal opportunity, we concluded that Mr. Hawkins violated merit system promotion principles.

Evidence of a Retaliatory Motive

Having established that Mr. Clay and Mr. Hawkins did not act reasonably in making the selections, we next reviewed the facts to determine whether there was evidence of a retaliatory motive towards any of the complainants. In addition to statements showing animus towards specific individuals, which are discussed later, Mr. Clay and Mr. Hawkins made statements that showed animus towards employees who went outside CAVHCS with their complaints. For example, Mr. Clay testified that these persons were not team players and he referred to them as persons trying to "sabotage" the integration.

Mr. Clay and Mr. Hawkins engaged in activities towards CAVHCS staff that demonstrated animus towards employees who did not conform to the Director's goals or who sought assistance from external reviewers. On June 15, 1997, Mr. Clay appeared on "Russo on the Spot," a local cable TV show which included a discussion of Mr. Clay's efforts to integrate the facilities and the problems he was facing. It is clear from Mr. Clay's statements on the program that he took the complaints raised to Congressman Everett early on in 1997 as a personal attack.

Mr. Clay and Mr. Hawkins felt that such reviews were only slowing the progress of the integration. For example, at the beginning of the integration Mr. Clay issued numerous e-mail messages entitled "resistance to change." Some of the e-mail messages encouraged unity, while concurrently blaming staff who, in his view, were not "on board" with the integration.

In an August 12, 1997, e-mail to all staff, just as the OIG was beginning a second onsite review at CAVHCS, Mr. Clay made it known that employees who were not "on board" with the integration would be treated differently. Mr. Clay stated in his e-mail,

> "We need to reserve promotions and the most sought after assignments for the people who do the most to drive change forward… not the ones who tried to slow it down or stop it. Simply put, we should send out psychological paychecks…praise, attention, honors or awards…in a more discriminating manner, rewarding only those people who get with the new organization. Next we need to consider the steps to take with negative reinforcement. Just as we need to offer everybody a powerful new payoff for supporting change, we also need to make it expensive for our people to fight it. Resistance should produce a more unpleasant set of results than change does. Sticking with the status quo needs to be a painful, unsatisfying experience."

On several occasions during the course of the OIG investigations, Mr. Clay interfered with our efforts to conduct reviews by taking actions that would intimidate or dissuade employees from providing information to the OIG. For example, on September 22, 1997, Mr. Clay sent an e-mail message to CAVHCS service chiefs instructing them to inform all employees that anyone having telephone contact with the OIG must immediately prepare a report regarding that contact. After we discussed Mr. Clay's action with the VISN Director, he instructed Mr. Clay to retract the directive. Mr. Clay did so on September 25. Although the directive was withdrawn, employees testified that after they would meet with the OIG, they were approached by ***(b)(6)*** and asked to provide copies of any information that was provided to the OIG. Whatever their motives, CAVHCS management's actions would act to intimidate, or at least dissuade, employees from providing information to the OIG.

Like Mr. Clay, Mr. Hawkins expressed his views that employees who sought assistance from external reviewers would be viewed as antagonists. Mr. Hawkins' views became clear at a November 4, 1997, Director's staff meeting, which was attended by about 60 managers and other staff, where he said,

> "…[W]e are getting to be a little bit silly with the things that you or your staff bring up to the IG, and *there is a place not in heaven for you* and you need to understand that…We come here supposedly to work together to take care of patients…this infighting…Things that are reported to the IG about Clay's house in New Orleans or somebody getting this job… *The IG is not going to come back here and take care of anybody – nobody – they don't have a cover to put over anybody.* So if you are going to tell it, tell the truth. And for those of you that are doing it remember my first statement." (emphasis added)

The statement demonstrates top management's displeasure with employees who would bring matters to the OIG. The effect of such actions, management's overt efforts to obtain information that was provided to the OIG, and Mr. Hawkins' statements at the November 4, 1997 meeting, is that of intimidation which would cause employees to be reluctant to provide information.

Mr. Clay's intention to gain support from his employees against certain other staff, is seen in another e-mail to all staff when he issued a prayer to the CAVHCS in February 1998. The Director wrote to all staff,

> "Heavenly father, only you fully know the collective stress and strain we have to bear in carrying out the mission of Central Alabama Veterans Health Care System (CAVHCS). *Only you fully know who are not in support of our mission and goals*. However, we are all your children and employees of the CAVHCS organization. We pray for all of our employees and their efforts to make CAVHCS a more responsive organization… one that will put "customers first" in every way…every day. Amen." (emphasis added)

In having his employees pray for those who are perceived as not supporting the Director's way of thinking, Mr. Clay further encouraged conflict rather than unity; an essential element for a successful integration. In evaluating the gravity and effect of Mr. Clay's and Mr. Hawkins' quoted comments, witnesses informed us that they viewed such remarks as threats and that opposing management had implied consequences in the next life as well as this one. One employee we interviewed questioned Mr. Clay's use of prayer in a Federal facility because of the long-standing constitutional requisite in maintaining a separation between Church and State.

Mr. Clay and Mr. Hawkins demonstrated a pattern of showing animosity towards managers who provided advice or input that was not consistent with their plan. For example, Mr. Clay expressed a negative opinion about ***(b)(6)*** because ***(b)(6)*** provided him advice about possible RIFs which was inconsistent with Mr. Clay's stated position that there would not be any RIFs. Another example, is the animosity shown towards ***(b)(6)*** and ***(b)(6)*** about the staff picnic. At the end of Fiscal Year 1997, Mr. Clay and Mr. Hawkins planned a picnic for employees from both facilities and their families at a cost of approximately $25,000 which they intended to pay for from medical appropriations. Mr. Hawkins and Mr. Clay ignored the advice given by their managers that it was improper to use medical care appropriations to pay for the picnic. Because their advice was disregarded, the managers were compelled to go outside CAVHCS to prevent the misappropriation of funds. This incident upset both Mr. Clay and Mr. Hawkins, who both testified that they did not consider these managers to be trustworthy.

Employees Who Did Not Engage in Protected Activities Were Treated Differently by Management.

Our review showed that employees who were not known, or perceived, to have raised issues outside CAVHCS, including providing information to the OIG or Congressman Everett, were treated differently than employees who engaged in, or were suspected of engaging in, protected activities. Some specific examples follow:

Preferential Treatment of ***(b)(6)*** *and* ***(b)(6)***

The selection panel was initially provided a certification and applicant information for 10 service chief positions: ***(b)(6)***, ***(b)(6)***, ***(b)(6)***, ***(b)(6)***, ***(b)(6)***, ***(b)(6)***, ***(b)(6)***, ***(b)(6)***, ***(b)(6)***, and ***(b)(6)*** Service. After the panel met and rated and ranked the candidates for ***(b)(6)*** Service, but before they completed the process for ***(b)(6)*** Service, Mr. Hawkins cancelled these two announcements and proceeded to fill the positions through non-competitive appointments. There was no compelling reason to cancel the announcements particularly since they had sufficient competition from which Mr. Hawkins could make a selection. One of the panel members testified that the cancellations and subsequent appointment gave the appearance of pre-selection.

With respect to ***(b)(6)*** Service, ***(b)(6)*** was ranked tenth when he applied for the integrated Chief, ***(b)(6)*** Service position. Prior to this, ***(b)(6)*** was the Chief, ***(b)(6)*** Service for the East Campus. If Mr. Hawkins had adhered to his stated objective of selecting from the top three candidates and selecting someone the panel was comfortable with, ***(b)(6)*** would not have even been considered because of his low ranking. However, after the panel ranked the candidates, Mr. Hawkins cancelled the announcement, created a new position titled, Chief, ***(b)(6)***, and placed ***(b)(6)*** into it as a reassignment. In short, Mr. Hawkins went outside the process when the process did not provide him the result he wanted. ***(b)(6)*** was not involved in any investigation nor was he perceived to have blown the whistle for any reason.

Mr. Hawkins cancelled the Chief, ***(b)(6)*** Service announcement and created a new position, Chief, ***(b)(6)*** Service. He reassigned ***(b)(6)***, ***(b)(6)***, ***(b)(6)*** Service, East Campus, to the position. ***(b)(6)*** was not involved in any of the OIG investigations, nor was she perceived as being involved. Mr. Hawkins testified that he made the decision to combine the services and reassign ***(b)(6)*** because he had "a displaced employee who has been an outstanding performer ... done and outstanding job [in] ***(b)(6)***." Mr. Hawkins further stated that ***(b)(6)*** experience in ***(b)(6)*** was enough for her to be able to do the ***(b)(6)*** jobs. We found Mr. Hawkins' reasons unpersuasive since ***(b)(6)*** had no experience in either ***(b)(6)*** Service, as required, and will continue to require, extensive training for her new position.

Mr. Hawkins had only been at the CAVHCS for about five months when he made this decision. Given the short period of time and the fact that ***(b)(6)*** was the ***(b)(6)*** in ***(b)(6)*** and, therefore not under Mr. Hawkins direct supervision, it is unlikely that he had sufficient contact with her to personally evaluate her performance as a manager. From ***(b)(6)*** testimony, it appears that Mr. Hawkins primary interaction with her was with the dedication of the nursing home. Mr. Hawkins could have cancelled the announcement for the Chief, ***(b)(6)*** Service and appointed ***(b)(6)***. However, the position was only a GS-12, which would have meant a

reduction in grade for ***(b)(6)***. Instead, Mr. Hawkins created a new position, Chief, ***(b)(6)***Service, which classified as a GS-13, and appointed ***(b)(6)***to the position. This represents another example of preferential treatment to an employee who did not engage in protective activities.

Mr. Hawkins' actions concerning ***(b)(6)***and ***(b)(6)***were unprecedented and did not occur in any other service. This gave rise to concerns by incumbents required to compete for other positions, that certain staff received preferential treatment because they did not engage in protected activities.

Other evidence that supports our conclusion that the facts relating to ***(b)(6)***'s reassignment is evidence of preferential treatment is Mr. Hawkins' reasons for the cancellation. Mr. Hawkins testified that he cancelled the announcement because the two incumbents, ***(b)(6)***, Chief, East Campus, and ***(b)(6)***, Chief, West Campus, had decided to take buyouts. The evidence shows that, at the time the decision was made, ***(b)(6)***, who did cooperate with the OIG investigation of the Chief of ***(b)(6)***Service at the East Campus, had not submitted any formal request for a buyout. She merely indicated that she might be interested in a buyout if she was not selected for the Chief position. Documents show that the submission was for survey purposes only and that ***(b)(6)***was not formally offered a buyout until after Mr. Hawkins cancelled the announcement for the Chief, ***(b)(6)***Service position and appointed ***(b)(6)***as the Chief, ***(b)(6)***Service. We found Mr. Hawkins' testimony that he was unaware that ***(b)(6)***was still interested in the position to be disingenuous.

(b)(6)testified that when she heard that Mr. Hawkins was going to cancel the announcement because of the buyout, she informed him that ***(b)(6)***interest in a buyout was contingent on her not getting the position. She said Mr. Hawkins responded by saying "they are on the list, they are out."

Employees who responded to the buyout survey were specifically told in the e-mail that it was not an offer and was not binding. Furthermore, the survey was conducted on June 2, 1997, several months before the announcement was issued and well before the certification and the selection files were given to the panel for review. Mr. Hawkins' reason for canceling the announcement, i.e. that ***(b)(6)***and ***(b)(6)***had asked for buyouts is inconsistent with the fact that he gave the selection package to the panel for review. In our opinion, a reasonably prudent manager in like or similar circumstances would have noted the discrepancy and would have discussed the matter with the affected employee(s) before canceling the announcement. Mr. Hawkins' testimony that he knew ***(b)(6)***"applied" for the buyout reflects his lack of understanding that the buyout list was merely a survey, something he, as the Associate Director, should have known.

Preferential Treatment of Ms. Jackie Wilson and ***(b)(6)***

The preferential treatment given by Mr. Clay and Mr. Hawkins to the subjects of two OIG criminal investigations further supports our conclusion that supervisors who were known or suspected to be involved in protected activities were treated differently from other supervisors.

At the time of the selection process for the Chief, Environmental Management Service (EMS) position, Ms. Wilson was under indictment by the Government for criminal acts, which occurred in the performance of her duties.[7] Because of the indictment, she was suspended without pay from her position at the medical center before the position was announced. We reviewed the selection files and found nothing in the documents to indicate that Ms. Wilson had submitted an application for the position. ***(b)(6)***, ***(b)(6)***, testified that they added Ms. Wilson's name to the list because they felt it was necessary to include her because if the indictment "didn't hold" and the charges were not substantiated, it would not have been fair to leave her out of the selection process.

Even after Ms. Wilson was indicted, Mr. Clay and Mr. Hawkins first returned her to her original assignment. After objections were raised, she was merely detailed to another area. It was not until the OIG requested assistance from the VISN and General Counsel that CAVHCS management, in response to an order by the VISN Director, suspended Ms. Wilson without pay pending the outcome of the criminal case. Ms. Wilson pled guilty and resigned from Federal service.

The evidence shows similar preferential treatment towards ***(b)(6)***, who was the Chief of ***(b)(6)*** Service at the East Campus. ***(b)(6)*** was given a buyout even though he was the subject of an ongoing criminal investigation. The documents provided to us show that ***(b)(6)*** did not submit his name for a buyout when the survey was conducted on June 2, 1997. Shortly after the survey, the OIG began an investigation into alleged illegal and improper activities by ***(b)(6)***. On October 17, 1997, shortly after Mr. Hawkins was informed by the OIG that ***(b)(6)*** might be indicted for theft, management approved the $25,000 buyout.

Mr. Hawkins indicated that he knew there were problems with ***(b)(6)*** Service under ***(b)(6)*** direction and agreed that as a result of that, he got a buy out. Other witnesses testified that they had brought issues regarding possible criminal and other inappropriate activities concerning ***(b)(6)*** to management's attention in the past but that the complaints were ignored. Mr. Hawkins further testified that he had a retirement party at his home for ***(b)(6)*** after his retirement. Approval of a buyout for an employee under investigation for activities related to his position, criminal and/or administrative, particularly when the employee did not indicate an interest in the buyout until after the investigation commenced, is another example of management treating an employee who did not engage in a protected activity differently.

[7] Ms. Jackie Wilson was awarding contracts to a friend for work that was never performed.

Preferential Treatment of ***(b)(6)***

Mr. Hawkins' selection of ***(b)(6)*** for one of the three patient ombudsman positions is another example of preferential treatment to an employee who did not engage in a protected disclosure. Prior to being selected for this position, ***(b)(6)*** was a travel clerk at the East Campus. She was responsible for processing Mr. Hawkins permanent change of station (PCS) vouchers. Mr. Hawkins moved the processing of his PCS vouchers to the East Campus after being questioned by the travel clerk at the West Campus about not providing necessary receipts.

Mr. Hawkins told us under oath that he initiated the transfer of his travel activities because his salary account changed from the West Campus to an East Campus cost center. In order to validate his response we reviewed the source documents from the Austin Finance Center Travel Section. The review showed that Austin staff continued to identify the West Campus as the permanent duty site for Mr. Hawkins throughout his PCS move. We noted that when the cost center did eventually change for the VA facility, it was redefined as a CAVHCS cost center, not a Tuskegee versus a Montgomery cost center.

We also interviewed the travel clerk at the West Campus to obtain her views on why Mr. Hawkins transferred his travel activities to the East Campus. The travel clerk believed it was because she had questioned his claim for mileage and insisted that his receipt for temporary quarters was not satisfactory. She also questioned him when he wanted to ship his third car along with his household goods.

In her testimony she said,

> "Well, I guess I feel it [the function] was taken away from me because I had the nerve to question something, and I also had put a comment on here I didn't pay the en-route travel…because I didn't feel it was proper and once that note was read, I believe it was upsetting, and I have already dug my grave when I was first phoned from Michigan by Mr. Hawkins. He wanted to ship his [third] POV and I said I would check it out and find out the cost. When I got back to him, I said I could not recommend it to the Chief of Fiscal that it would be cost efficient to the government, and his remark was who are you to say or who is Fiscal to say I can't ship my POV, and I said, well, sir, I am just reading the regulations to you. …I recommended what I thought the federal regs [regulations] required of me, and I kn[e]w right then by his response that I chopped my head off."

We followed-up and found that Mr. Hawkins did not have his third car moved with his household goods; a family member drove the car to the new duty station. ***(b)(6)*** did not question any of the figures submitted by Mr. Hawkins nor did she request

additional receipts for lodging expenses beyond a hand-generated receipt. She also did not question the meal expenses posted by Mr. Hawkins.

Shortly after processing Mr. Hawkins' last PCS voucher, ***(b)(6)*** was selected for the ombudsman position, which was a promotion to a GS-7 with promotional potential to a GS-9. Irregularities with Mr. Hawkins' PCS vouchers were discussed in Part II, Issue 2 section of this report. In addition, the HRM team identified serious problems with the selection process for the ombudsman positions which are discussed later in Part III, Issue 2. ***(b)(6)*** selection is consistent with Mr. Hawkins' giving preferential treatment to employees who do not question his actions and are not involved with providing information or allegations to the OIG or the Congress.

Preferential Treatment of ***(b)(6)***

In May 1997, Mr. Clay selected ***(b)(6)*** as the ***(b)(6)***. Prior to her selection, ***(b)(6)*** was Chief of ***(b)(6)***, a position that has since been ***(b)(6)***. Mr. Clay convened a review panel for the ranking and rating of the seven applicants for the ***(b)(6)*** position. Mr. Clay established no specific criteria and left the panel members to decide among them what criteria to use to rate the candidates. The panel scored the candidates based on their performance appraisals, qualification rating factors, types of awards for performance dealing with the position announcement for management skills, computer/technical knowledge, and written skills. The panel scored ***(b)(6)*** highest, with ***(b)(6)*** second. ***(b)(6)*** was Chief of ***(b)(6)*** at West Campus and ***(b)(6)*** was Chief of ***(b)(6)*** at West Campus. ***(b)(6)*** scored seventh. The panel submitted the names of ***(b)(6)*** and ***(b)(6)*** as their top ranked candidates to Mr. Clay on March 24, 1997.

Four days later, Mr. Clay sent the list back to the panel asking them for three names rather than two, and asking that they interview all of the candidates. Mr. Clay told the panel that he had spoken with the ***(b)(6)***, ***(b)(6)***, ***(b)(6)***, about what CAVHCS should be looking for in the job. In his memorandum to the panel requesting additional "staff work," Mr. Clay stated that he and ***(b)(6)*** had decided that interviews were necessary to ascertain the candidates' "visionary views on ***(b)(6)***" and disclose their "knowledge, management skills and abilities about all of the components of ***(b)(6)***." According to Mr. Clay, ***(b)(6)***[8] and he decided that the successful candidate

[8] ***(b)(6)*** did not have a specific recollection, which corroborated Mr. Clay's testimony. ***(b)(6)*** recalled some conversation with Mr. Clay in which ***(b)(6)*** was discussed, but did not recall whether this conversation occurred before or after her selection as CAVHCS ***(b)(6)***. ***(b)(6)*** said he thought she would be a good choice based on his involvement with her on ***(b)(6)*** issues, although he did not recommend that she be selected. ***(b)(6)*** had no knowledge of candidates ***(b)(6)***, ***(b)(6)***, or ***(b)(6)***, and did not discuss ***(b)(6)*** in comparison with other candidates. He had never supervised ***(b)(6)***. ***(b)(6)*** described ***(b)(6)*** as Mr. Clay's "choice," which if made before the selection, is consistent with a conclusion that Mr. Clay reconvened the panel to give them another chance to rank ***(b)(6)*** as a top three candidate. However, ***(b)(6)*** could not commit to a date of his conversation with Mr. Clay about ***(b)(6)***.

should have a strong background in ***(b)(6)***. Mr. Clay explained that his request that the panel do a second review was based on his impression that the panel had "not done [it] the way that it should have been done, in terms of looking [at] and reviewing the folders, and discussing among themselves, who would be the most appropriate candidate for the position."

In response to Mr. Clay's memorandum, the panel reconvened, drew up a list of seven questions to ask each candidate, and interviewed the applicants. ***(b)(6)*** dropped out of the competition voluntarily. The second ranking included ***(b)(6)***, ***(b)(6)***, and ***(b)(6)***, listed in that order, but without a specific ranking of first through third. Mr. Clay interviewed all three candidates in 15-minute interviews and selected ***(b)(6)***. We concluded that Mr. Clay's actions evidence preferential treatment for an employee, ***(b)(6)***, who did not engage in a protected activity.

Mr. Clay's arbitrary rejection of the panel's first ranking and his charge for them to reconvene supports the conclusion that he either did not want to select ***(b)(6)*** or ***(b)(6)*** and/or he desired to select ***(b)(6)***. After first leaving the panel to decide among themselves the ranking criteria, Mr. Clay dismissed their ranking on the grounds that they ranked the candidates incorrectly. Inasmuch as the panel was free to decide what criteria to use, there was, by definition, no "wrong answer." Nevertheless, Mr. Clay decided, after he had received a list with only two West Campus incumbents, including one who was previously identified by the Montgomery union local as part of the clique (***(b)(6)***), that the panel process should be changed and redone.

Mr. Clay also alluded to the fact that the ***(b)(6)*** position may not have been properly announced. The position was announced as a series ***(b)(6)*** management position. Mr. Clay stated he had some concerns about this series, and alleged that ***(b)(6)***, Chief, ***(b)(6)***, and ***(b)(6)*** may have discussed this issue beforehand so as to announce the job in the series that ***(b)(6)*** was best qualified in to increase his chances of being selected. ***(b)(6)*** and ***(b)(6)*** have denied any collusion in this regard. Mr. Clay did not cancel and reannounce the ***(b)(6)*** position based on an incorrect job series.

Preferential Treatment of ***(b)(6)***

Another example brought to our attention was the action taken by Mr. Hawkins against ***(b)(6)***, who, for several years prior to Mr. Hawkins' arrival, was the Acting Chief of ***(b)(6)*** Service at the East Campus. Within a month after Mr. Hawkins arrived, he removed ***(b)(6)*** from his position, and placed ***(b)(6)*** into the Acting Chief position. ***(b)(6)*** was a GS-11 ***(b)(6)*** with no management experience.

Mr. Hawkins demonstrated his irritation with ***(b)(6)*** for cooperating with the OIG investigator in a later meeting with ***(b)(6)***, during which he verbally abused him

regarding his cooperation with the OIG.[9] Mr. Hawkins' actions concerning ***(b)(6)*** and ***(b)(6)*** show his proclivity to treat employees who are perceived as cooperating with the OIG differently from those who do not participate in a protected disclosure.

Specific Cases of Prohibited Personnel Actions

Out of the ten administrative service chief positions, five of the selectees had a prior relationship with the selecting official, Mr. Hawkins. ***(b)(6)***, and ***(b)(6)***, and ***(b)(6)*** and ***(b)(6)*** all worked for Mr. Hawkins at his last station, VAMC Saginaw. ***(b)(6)*** worked previously with Mr. Hawkins at VAMC, Hines. A sixth selectee, ***(b)(6)***, came from the same VISN as Mr. Hawkins. In fact, every applicant who had worked with Mr. Hawkins in Saginaw was selected for one of the integrated service chief positions even though most of them lacked the experience of other candidates.

Several incumbent managers who applied for these consolidated service chief positions alleged that they were not selected in retaliation for whistleblowing and/or cooperating with the OIG. We substantiated the allegations for four of the complainants: ***(b)(6)***, ***(b)(6)***, ***(b)(6)***, and ***(b)(6)***. We also substantiated that ***(b)(6)*** was retaliated against but the personnel action was a significant change of duties, not non-selection.

Non-selection of ***(b)(6)*** *as the* ***(b)(6)***

We substantiated the allegation that ***(b)(6)*** was retaliated against in violation of §2302(b)(8) and (b)(9). At the time of the integration, ***(b)(6)*** was the Chief, ***(b)(6)*** (***(b)(6)***) Service. He applied for and was not selected for the Chief, ***(b)(6)*** position, GS-12 or GS-13, Announcement 110-PR. ***(b)(6)*** was in charge of both campuses' ***(b)(6)*** functions from January 1997 until December 1997 when the new CAVHCS ***(b)(6)*** reported for duty. He received an outstanding rating for his work through March 1997. In addition, he was the only "safe" selectee identified by Mr. Lamm for RIF purposes. After his non-selection, ***(b)(6)*** transferred to the VAMC, ***(b)(6)***, ***(b)(6)***.

(b)(6) engaged in protected activities when he provided information to OIG criminal investigators in a theft investigation that resulted in the arrest of a VA employee at the East Campus in August 1997. ***(b)(6)*** also advised management that they were violating fiscal regulations in preparation for an employee picnic scheduled for late September 1997. ***(b)(6)*** disclosures met the Whistleblower Protection Act definition of a protected activity. His actions would also be considered covered under §2302(b)(9).

[9] Although we believe that the actions taken against ***(b)(6)*** may have been inappropriate, we did not render a specific finding on this issue. ***(b)(6)*** did not file a complaint and stated that he did not apply for the Chief position because he would not work for Mr. Hawkins.

Management had knowledge of ***(b)(6)*** protected activities. ***(b)(6)*** went to Mr. Hawkins with concerns about spending appropriated funds for a CAVHCS employee picnic. When ***(b)(6)*** met resistance from Mr. Hawkins, he discussed the spending of appropriated funds with his ***(b)(6)*** counterpart in VAMC Augusta, Georgia, who agreed that the expenditure of medical care appropriations on the picnic was inappropriate. Mr. Hawkins told us he learned that ***(b)(6)*** discussed the appropriateness of the picnic with VAMC Augusta staff on September 23, 1997. We also believe that Mr. Hawkins attempted to pressure ***(b)(6)*** to inappropriately use appropriated funds to pay for the September 1997 employee picnic (See Part II, Issue 2, Allegation 2).

Mr. Hawkins and Mr. Clay indicated that even though they did not have specific information regarding the source of an allegation, they could guess at the source based on the issue involved and who had knowledge of the issue. In addition to the picnic matter, the OIG review included a number of other ***(b)(6)*** issues. The local press specifically pointed to ***(b)(6)*** issues and the use of government credit cards, which were within ***(b)(6)*** area of responsibility. It is more likely than not that Mr. Hawkins and Mr. Clay suspected ***(b)(6)*** of providing information on these issues to Congressman Everett and/or the press. This is supported by a comment ***(b)(6)*** testified that Mr. Hawkins' made prior to the selection that "someone in ***(b)(6)***" would call the OIG to report on an action before the ink was dry on the minutes of the meeting. Mr. Hawkins also testified that he did not trust ***(b)(6)*** because of the picnic incident. When questioned about why he chose ***(b)(6)*** over ***(b)(6)***, Mr. Hawkins stated "I want to work with fair and honest people."

Management did not provide clear and convincing evidence that they would have taken the same action, non-selecting ***(b)(6)***, in the absence of the protected activities. Mr. Hawkins admitted that ***(b)(6)*** could have done the job as CAVHCS ***(b)(6)***, but that he preferred ***(b)(6)*** with whom he worked at his last duty station at VAMC Saginaw, MI. Mr. Hawkins informed us that ***(b)(6)*** was a good trainer, had a Masters Degree, and worked well with bringing groups of people together to work with each other.

We find these arguments unpersuasive. The selection files show that ***(b)(6)*** had less than 7 months experience as a ***(b)(6)***, GS-12 at the time of his selection compared to the more than 9 years ***(b)(6)*** had as a Chief, ***(b)(6)*** Service. It is also questionable whether Mr. Hawkins had much, if any, direct contact with ***(b)(6)*** in this position since ***(b)(6)*** was not promoted to the position until April 1997, just before Mr. Hawkins transferred to CAVHCS. Mr. Hawkins also admitted that he was never ***(b)(6)***' first line supervisor. Mr. Hawkins' reliance on ***(b)(6)***' Masters Degree is also unpersuasive to explain his selection, because in at least one other selection, ***(b)(6)***, the incumbent or another of the top three applicants had an advanced degree and was not selected.

Mr. Hawkins viewed ***(b)(6)*** as autocratic and selective in assisting staff at the facility. However, he admitted that he could not say whether ***(b)(6)*** had a good

(b)(6) section. Mr. Hawkins asked us to speak with two employees on this subject. One of the employees we spoke with said that the problems with ***(b)(6)*** predated ***(b)(6)*** tenure. The other employee said there were problems with two ***(b)(6)*** in the past, but he never felt obliged to speak to ***(b)(6)*** about them. ***(b)(6)*** West Campus supervisor respected him and believed he was a very good ***(b)(6)***. His supervisor at the East Campus prior to Mr. Hawkins' arrival also confirmed that ***(b)(6)*** was an excellent ***(b)(6)*** .

We concluded that Mr. Hawkins retaliated against ***(b)(6)*** in violation of § 2302(b)(8) and/or (b)(9). We also find that the protected activities were a significant factor in Mr. Hawkins' and Mr. Clay's decision not to select ***(b)(6)***. Mr. Hawkins had a local candidate who he said could do the job, but he did not trust him because of his protected activities. The employee brought legitimate concerns about spending appropriated funds on an employee picnic to the attention of the VISN and other external reviewers. He also disclosed other protected activities to external reviewers, which resulted in the arrest and prosecution of an employee. Within a limited timeframe thereafter, a little over a month after the picnic controversy, ***(b)(6)*** was denied the selection of the ***(b)(6)*** position.

Non-Selection of ***(b)(6)*** *as the Chief,* ***(b)(6)*** *Service*

We substantiated that ***(b)(6)*** was retaliated against in violation of §2302(b)(9). Prior to the integration, ***(b)(6)*** was the Chief of ***(b)(6)*** Service (now ***(b)(6)***) at the West Campus. At the time of the selection, he had more than 12 years experience in this position and had been rated highly successful for the 3 years preceding the selection.

Although ***(b)(6)*** admits that he did not make any complaints to the OIG or to Congressman Everett, he did cooperate with the OIG and GAO investigations. In addition, he provided information to ***(b)(6)***, at ***(b)(6)*** request, that he understood was requested by GAO. This upset Mr. Hawkins who called ***(b)(6)*** and questioned him about the information that was provided to ***(b)(6)***. One of the issues being investigated was the ***(b)(6)*** being installed in the renovation of buildings at the West Campus.

We have no direct evidence that Mr. Clay or Mr. Hawkins had specific knowledge with respect to whether ***(b)(6)*** made protected disclosures to the OIG to qualify him as a whistleblower under §2302(b)(8). However, there is sufficient circumstantial evidence that Mr. Clay and Mr. Hawkins had reason to suspect that he had engaged in protected activities. Given the circumstances at CAVHCS, particularly Mr. Clay's and Mr. Hawkins' statements that showed animus towards staff who disagreed with their position and/or provided information to Congressman Everett, the OIG or the GAO, we believe it is reasonable to conclude that CAVHCS management suspected ***(b)(6)*** was one of the non-supporters who was providing information to GAO or OIG damaging to CAVHCS management changes. In addition, ***(b)(6)*** testified

that he had disagreed with Mr. Hawkins on issues relating to the ***(b)(6)*** systems being installed in the Director's and Associate Director's quarters. Mr. Hawkins cited this issue as a reason for not selecting ***(b)(6)***. At a minimum, ***(b)(6)*** cooperation with the OIG would provide him protection from retaliation under §2302(b)(9).

(b)(6) did not rank in the top three candidates selected by the panel. However, the documents in the selection files relating to ***(b)(6)*** are incomplete, i.e., the panel's scores do not add up. The scores appearing in the selection memoranda, which were tabulated by ***(b)(6)***, are 10-9-9-8-8. However, these scores are not supported by the documents in the selection file. Only four summary score sheets were provided by CAVHCS. Two of those sheets give a score of 10, yet ***(b)(6)*** only received one 10. A third sheet has no total or interview component score, and the listed components total only 7. The fourth sheet gives the score of 9. Only three interview question notes sets are included, but there are four rating and ranking forms. There should be 5 sets of the summary sheets, ranking and rating forms, and interview questions.

There is no way to reconcile the panel's testimony, that they all participated in rating ***(b)(6)***, and the absence of documents supporting ***(b)(6)***s score. While these discrepancies alone may not account for ***(b)(6)***s failure to score in the top three candidates, it is our conclusion that the flaws in the process may have contributed to ***(b)(6)***s nonselection. Certainly, Mr. Clay and Mr. Hawkins were not precluded from selecting ***(b)(6)***, even though he did not score in the top three.

There is evidence of animus against ***(b)(6)*** by Mr. Hawkins. On March 5, 1998, CAVHCS announced a vacancy for an engineering service manager in the same job series and grade that ***(b)(6)*** occupies. Inasmuch as ***(b)(6)*** was known to be a nonselected GS-13 incumbent as a result of Mr. Hawkins' selection of ***(b)(6)***, it would have been appropriate to reassign ***(b)(6)*** to this position. However, ***(b)(6)*** was not selected and was assigned to temporary nonmanagerial duties. ***(b)(6)*** from VAMC ***(b)(6)*** who was also one of the eight candidates that applied for the ***(b)(6)*** position was selected. ***(b)(6)*** was an applicant for the ***(b)(6)*** position and was not ranked by the panel as one of the top three candidates. Also, Mr. Hawkins' comments in his interview, that he was not going to "kiss the butts" of the former incumbents like ***(b)(6)***, revealed an animus on the part of Mr. Hawkins towards ***(b)(6)***.

The person selected for the ***(b)(6)*** position, ***(b)(6)***, had previously worked with Mr. Hawkins at VAMC Saginaw. The panel scored ***(b)(6)*** third highest. The top-rated candidate was the Assistant Chief, ***(b)(6)*** Service, ***(b)(6)***, ***(b)(6)***. The second-highest rated candidate was the Supervisory ***(b)(6)***, VAMC ***(b)(6)***, ***(b)(6)***. Mr. Hawkins had rated ***(b)(6)*** outstanding as his immediate supervisor at VAMC Saginaw the same

month he was selected as Associate Director at CAVHCS. Neither of the other top two applicants had ever worked at the same facility as Mr. Hawkins. Because he did not interview any of the other candidates, Mr. Hawkins's would have no basis for determining whether · **(b)(6)** · · · · · · · was the best candidate for the position. We concluded that Mr. Clay and Mr. Hawkins violated 5 U.S.C. § 2302 (b)(9) in the nonselection of · **(b)(6)** · · · · · · · · · based on suspected information provided to the OIG.

*Non-selection of · **(b)(6)** · · · · · · · · · · · as the Chief, · **(b)(6)** · · · · · · · · · · · · · · · · · · Service*

We substantiated the allegation that · **(b)(6)** · · · · · · · · · · · · was retaliated against in violation of §2302(b)(8) and (b)(9). Prior to the integration, · **(b)(6)** · · · · · · · · · · · was the Chief of · **(b)(6)** · at the West Campus. He was selected for promotion into that position in February 1996. Prior to that time he was the Assistant Chief, a position he held for over 5 years. There is no evidence that · **(b)(6)** · · · · · · · was not performing at/or above a fully successful level in his position. In fact, both internal and external reviewers noted the cleanliness of the West Campus facility.

· **(b)(6)** · · · · · · · provided information to the OIG relating to the criminal investigation, and subsequent conviction, of Ms. Jackie Wilson. CAVHCS management was aware of the fact that · **(b)(6)** · · · · · · · was providing information relating to Ms. Wilson because · **(b)(6)** · · · · · · · · received a memorandum from · **(b)(6)** · · · · · · · · requiring that he send the documents to · **(b)(6)** · · · · · · · before they were sent to the OIG. · **(b)(6)** · · · · · · · informed the OIG about this when it occurred.

The selection panel ranked · **(b)(6)** · · · · · · · second. He tied with the applicant who was ultimately selected, · **(b)(6)** · · · · · · · · · · · · We reviewed the documents in the selection file and noted negative comments on one of the evaluation forms, which showed that the scorer inappropriately used his knowledge of an experience with · **(b)(6)** · · · · · · · · This knowledge was outside the scope of the information obtained during the interview or from the documents in the selection file to rank · **(b)(6)** · · · · · · · ·

We reviewed management's reasons for selecting · **(b)(6)** · · · · · · and not selecting · **(b)(6)** · · · · · · · , and concluded that they were pretextual. Mr. Hawkins described · **(b)(6)** · · · · · · · · as being "one of the good old boys" who had been trained in · **(b)(6)** · · · · · · · and had not gone to any training classes. A comparison of · **(b)(6)** · · · · · · · · and · **(b)(6)** · · · · · · · · 's records does not show any significant difference in their training. When confronted with this during a follow-up interview, Mr. Hawkins backed away from his original position.

Mr. Hawkins further indicated as a reason for not selecting · **(b)(6)** · · · · · · · · was that he thought · **(b)(6)** · · · · · · · could have "done better" during the 2 to 3 months he took over the East Campus after Ms. Jackie Wilson was removed. Considering the short period of time that · **(b)(6)** · · · · · · · was responsible for · **(b)(6)** · · · · · · · · · · · , Mr. Hawkins' criticisms of his work seemed premature and unfair. This is particularly true given the number of complaints about the condition of the East Campus, which was under Ms. Wilson's management for years.

Mr. Hawkins also cited his prior experience working with · ***(b)(6)*** · · · · · as the reason for his selecting · ***(b)(6)*** · · · · · for the position. In reality, Mr. Hawkins did not have a sufficient, or even a recent, working relationship with · ***(b)(6)*** · · · · · upon which he could determine that · ***(b)(6)*** · · · · · was better qualified for the position than · ***(b)(6)*** · · · · · · · or any other candidate. He knew · ***(b)(6)*** · · · · · when he was at the VAMC Hines, Illinois in the 1980's, almost 10 years prior to this selection. He was never · ***(b)(6)*** · · · · · ' supervisor and had no direct relationship with him. According to · ***(b)(6)*** · · · · · , he knew Mr. Hawkins, but not well. He stated that they would occasionally attend meetings together.

Given statements by Mr. Clay and Mr. Hawkins showing the general animus against employees who provided information to, or otherwise cooperated with, the OIG, and the lack of a reasonable explanation for not selecting · ***(b)(6)*** · · · · · · · for the position, we concluded that Mr. Clay and Mr. Hawkins retaliated against · ***(b)(6)*** · · · · · · · in violation of §2302 (b)(8) and/or (b)(9).

Nonselection of · ***(b)(6)*** · · · · · · · · · · · · · · · *as* · ***(b)(6)*** · · · · · · · · · · · · ·

We substantiated the allegation that · ***(b)(6)*** · · · · · · · · · · was retaliated against in violation of §2302(b)(8) and (b)(9). Prior to the integration, · ***(b)(6)*** · · · · · · · · · · was the Chief of · ***(b)(6)*** · · · Service at the West Campus, a position he had held since 1989. For the 10 years prior to that, · ***(b)(6)*** · · · · · · · · · · was the Assistant Chief at the East Campus; and · ***(b)(6)*** · · · · · · · was his supervisor. His SF171 documents an additional 6 years working in various positions in VHA's · ***(b)(6)*** · · · · service at other medical centers. · ***(b)(6)*** · · · · · · · · · · · has a Bachelor's Degree. · ***(b)(6)*** · · · · · · · · · · · s records show outstanding performance evaluations and our review failed to identify anyone, other than Mr. Clay or Mr. Hawkins, who criticized · ***(b)(6)*** · · · · · · · · · · · · work.

It is undisputed that · ***(b)(6)*** · · · · · · · · · · made protected disclosures to Congressman Everett and to the OIG. It is also clear that Mr. Clay and Mr. Hawkins identified him as a "whistleblower" prior to this selection. One of the earliest was Mr. Clay's reference to · ***(b)(6)*** · · · · · · · · · · as the complainant during his appearance on "Russo on the Spot" on June 15, 1997. In fact, Mr. Clay's statements on the local television program also demonstrate animus towards · ***(b)(6)*** · · · · · · · · · · for filing an EEO complaint about his nonselection for the Chief · ***(b)(6)*** · · · · · · · · · · · · · · position.

With respect to the nonselection of · ***(b)(6)*** · · · · · · · · · · for the integrated service chief position, we concluded that CAVHCS management could not provide a reasonable explanation for the nonselection. Furthermore, statements made by Mr. Clay and Mr. Hawkins during their various interviews with the OIG show a strong animus towards · ***(b)(6)*** · · · · · · · · · · because of his protected activities.

Mr. Clay provided no explanation for the nonselection of · ***(b)(6)*** · · · · · · · · · · . He simply relied on Mr. Hawkins. We would, however, have found any explanation by Mr. Clay that was a criticism of · ***(b)(6)*** · · · · · · · · · · to be contrived because in April 1997, just

before · ***(b)(6)*** · · · · · · · · · · · · nonselection for the · ***(b)(6)*** · position, Mr. Clay approved an outstanding performance rating for him.

Mr. Hawkins noted several areas where he thought · ***(b)(6)*** · · · · · · · · · · was less qualified than · ***(b)(6)*** · · · · · · · , the selectee for · ***(b)(6)*** · · · · · · · · · · · · · position. Mr. Hawkins testified that · ***(b)(6)*** · · · · · · · · · · never gave him reports on time, passed on work to · ***(b)(6)*** · · · · · · · · · · · · · , the Assistant Chief in · ***(b)(6)*** · · · Service at the West Campus, and was · ***(b)(6)*** · · · · · · · · , like he "had retired already." He admitted, however, that he did not have much opportunity to work with · ***(b)(6)*** · · · · · · · · · · because · ***(b)(6)*** · · · · · · · · · · was · ***(b)(6)*** · · · · · · · · · · for about six weeks after Mr. Hawkins arrived. Mr. Hawkins also implied that · ***(b)(6)*** · · · · · · · · · · had identified a · ***(b)(6)*** · · · · · · · · · · · · · which did not exist. He also stated that he did not get the kind of · ***(b)(6)*** · · · reports that he had asked · ***(b)(6)*** · · · · · · · · · · to prepare.

Having reviewed all of the facts, we concluded that Mr. Hawkins' reasons for not selecting · ***(b)(6)*** · · · · · · · · · · were pretext. On July 30, 1997, when · ***(b)(6)*** · · · · · · · · · · · took · ***(b)(6)*** · , Mr. Hawkins permanently reassigned · ***(b)(6)*** · · · · · · · · · · · · · · ***(b)(6)*** · · · · · · · · · · · duties to · ***(b)(6)*** · · · · · · · .[10] Mr. Hawkins provided no evidence to support his position that reports were not prepared as requested. We also compared reports prepared by · ***(b)(6)*** · · · · · · · and those prepared by · ***(b)(6)*** · · · · · · · · · · and did not find any significant difference. We also determined that Mr. Hawkins' criticism against · ***(b)(6)*** · · · · · · · · · · concerning the · ***(b)(6)*** · · · · · · · · · · · · · · was unjustified.

We compared the documents that were reviewed by Mr. Hawkins and the panel in making this selection and could find nothing that would show that · ***(b)(6)*** · · · · · · · · was more qualified, or even as equally qualified, as · ***(b)(6)*** · · · · · · · · · · · for the position. For example, although there is an indication that · ***(b)(6)*** · · · · · · · has been employed by the Federal Government since 1983, she only provided information about her experience relating back to July 1995 when she was appointed as the · ***(b)(6)*** · · · · · · · · · · · · · at the VAMC Saginaw. In short, the records in the selection file show that she has only 2 years of experience as a fiscal manager compared to · ***(b)(6)*** · · · · · · · · · · · · · extensive · ***(b)(6)*** · · · and managerial experience. In addition, she provides very little explanation of her duties and responsibilities whereas · ***(b)(6)*** · · · · · · · · · · · provided significantly more information relevant to the position. Based on our review of the selection documents and interviews with the panel, we found that · ***(b)(6)*** · · · · · · · · · · · · · score was lowered because he refused to respond to the union's questions, as he thought the questions were inappropriate and that having the union on the panel violated his right to privacy. We agree.

· ***(b)(6)*** · · · · · · · · · · · placed third in the panel's ranking. We reviewed the documents submitted by the applicant who was ranked second and can find no viable explanation why this candidate was ranked higher than · ***(b)(6)*** · · · · · · · · · · · · . This candidate's application shows 4 years of work experience which included 1½ years as a GS-12 ·

[10] Because this represents a significant change in duties and occurred shortly after the complaints to Congressman Everett became known, and · ***(b)(6)*** · · · · · · · · · · had filed an EEO complaint regarding his nonselection for the · ***(b)(6)*** · position, we conclude that this was retaliation under §2302(b)(8) and (b)(9).

(b)(6) in VHA, 1½ years as a ***(b)(6)*** in VBA and less than 1 year as an ***(b)(6)*** in VBA. In addition to not having any experience as a ***(b)(6)***, or even an Assistant ***(b)(6)***, the applicant had no supervisory or managerial experience. The documents contained no supervisory ratings, other than a fully successful performance evaluation, and the applicant did not want his supervisor contacted. It is, in our view, inconceivable that this candidate was rated and ranked higher than ***(b)(6)*** and ***(b)(6)***. This just exemplifies the problems already discussed regarding the selection panel.

With respect to motive, both Mr. Clay and Mr. Hawkins made numerous statements throughout their respective testimonies that showed an intense dislike for ***(b)(6)*** because of his protected activities. Mr. Clay testified that there were a number of "challenges" in the integration which he blames on "outside interference" caused by people who don't like something and "it's reported to the Congressional office" which "interferes with our ability to manage" which he blames on ***(b)(6)***. Mr. Clay also named ***(b)(6)*** as the source of complaints about travel which were investigated by the OIG.

Like Mr. Clay, Mr. Hawkins made a number of derogatory remarks about ***(b)(6)*** and his protected activities. Mr. Hawkins referred to ***(b)(6)*** as "Mr. Untouchable" and, when asked to explain, referred to the fact that ***(b)(6)*** was the source of information to Congressman Everett. He testified that he did not trust ***(b)(6)*** or ***(b)(6)*** because the information that was the basis for the investigations could have only come from them. To support his position, Mr. Hawkins cited the investigation regarding the alleged misuse of Government American Express cards and stated that he suspected the information came from ***(b)(6)*** because ***(b)(6)*** had approached him on the issue before the investigation was initiated. Mr. Clay testified that Mr. Hawkins had told him about this issue.

Based on our analysis of the facts, we concluded that ***(b)(6)*** nonselection and permanent change of duties was in retaliation for making protected disclosures and for filing an EEO complaint which are prohibited personnel practices under §2302 (b)(8) and (b)(9) respectively.

Nonselection of ***(b)(6)*** *as the* ***(b)(6)***

We did not substantiate the allegation that the nonselection of ***(b)(6)*** for the ***(b)(6)*** position was in retaliation for engaging in protected activities. The second incumbent for the integrated financial position was ***(b)(6)***, the Chief of ***(b)(6)*** Service at the East Campus. The documents in the selection file show that ***(b)(6)*** held this position for 20 years prior to the selection of ***(b)(6)*** in November 1997.

(b)(6) did make protected disclosures and cooperated with the OIG in various investigations, particularly in the criminal investigation of Ms. Jackie Wilson. Mr. Hawkins and Mr. Clay were aware of the investigation and Mr. Hawkins testified that

he did not trust ***(b)(6)*** and related his lack of trust to the various OIG investigations.

Although we believe that ***(b)(6)*** should have been ranked in the top three, we do not conclude that his nonselection for the ***(b)(6)*** position was in retaliation for whistleblowing because we believe a reasonable manager would have selected ***(b)(6)***. The information we obtained showed that, unlike the West Campus, there was some performance problems with the management of ***(b)(6)*** Service at the East Campus under ***(b)(6)***.

Change in Duties for ***(b)(6)****, Chief of* ***(b)(6)*** *Service*

We substantiated the allegation that ***(b)(6)*** was retaliated against in violation of §2302(b)(8) and (b)(9) when his duties and responsibilities as the Chief of ***(b)(6)*** Service were eliminated in March 1998. We did not substantiate that ***(b)(6)*** was retaliated against when he was not promoted to a GS-13 through accretion of duties.

(b)(6) was the Chief of ***(b)(6)*** Service at the East Campus. He engaged in protected activities when he brought issues to the attention of Mr. Clay regarding the activities of ***(b)(6)***, the Chief of ***(b)(6)*** Service at the East Campus, including the misuse of ***(b)(6)***, ***(b)(6)***, etc. In addition, ***(b)(6)*** was contacted by and cooperated with the OIG during an investigation of ***(b)(6)***. In addition, ***(b)(6)*** complained to CAVHCS management about the misuse of Government facilities for non-Government related purposes. We found no credible evidence that ***(b)(6)*** was other than a good manager/supervisor. In fact, Mr. Clay approved a highly successful rating for him in 1997. ***(b)(6)***'s former supervisor, ***(b)(6)*** testified that ***(b)(6)*** was an excellent supervisor.

Although part of the initial integration plan, an integrated position for the Chief of ***(b)(6)*** Services was never announced. As previously discussed, a new position, Chief of ***(b)(6)*** Service was created for ***(b)(6)*** who was being displaced as the result of the integration in ***(b)(6)*** Service. ***(b)(6)*** provided us with a copy of a position description, which detailed his current duties, and responsibilities, which he thought, should be classified at the GS-13 level. ***(b)(6)*** stated that he provided the position description to Mr. Hawkins prior to the panel and reassignment of ***(b)(6)***, but Mr. Hawkins failed to take action on it, thus denying him a promotion by accretion of duties. We asked VA Central Office HRM officials to classify the position description; they classified it as a GS-12. Based on this assessment, we did not find any prohibited personnel action with the non-promotion of ***(b)(6)*** through accretion of duties.

We next reviewed the creation of the new position and the reassignment of ***(b)(6)*** who had no prior training or experience in either ***(b)(6)*** Services. Given the general animus that management had towards employees who

were known, or suspected, to be providing information to the Congress and/or the OIG, we concluded that the evidence would not support a claim of a prohibited personnel action unless it was found that the reassignment of ***(b)(6)*** violated a law, rule, or regulation.

On March 23, 1998, ***(b)(6)*** was notified by ***(b)(6)*** of a realignment of positions, which showed that his duties and responsibilities as manager and supervisor for ***(b)(6)*** Service were being eliminated and that he was effectively placed under the supervision of another service. This constitutes a significant change in duties which is a personnel action under §2302(a). Considering that the VISN Director and CAVHCS were instructed by VA Central Office, at the request of the OIG, not to take any action affecting any of the employees who had complained to the OIG about the selection process, we can only conclude that the action was in retaliation for engaging in protected activities which is a violation of §2302(b)(8) and/or (b)(9).

(b)(6)*, Chief of* ***(b)(6)*** *Services*

(b)(6) complained that she was treated unfairly with respect to the cancellation of the announcement for the integrated Chief of ***(b)(6)*** Services position. We found that ***(b)(6)*** engaged in protected activities because she provided information to the OIG relating to issues in the administrative investigation of ***(b)(6)***. ***(b)(6)*** applied for the integrated Chief, ***(b)(6)*** Service position that was announced in August 1997. At the time ***(b)(6)*** was the Chief of ***(b)(6)*** Service at the West Campus at the GS-11 level. The integrated position was a GS-12. As discussed, the Chief of ***(b)(6)*** Service position was pulled back from the selection panel and the announcement was cancelled by Mr. Hawkins. Mr. Hawkins subsequently created a new position, Chief of ***(b)(6)*** Service, at the GS-13 level and reassigned ***(b)(6)*** to the position without competition and without a ranking by a selection panel. After Mr. Hawkins announced ***(b)(6)*** appointment, ***(b)(6)*** accepted a buyout and retired.

Because the cancellation of a position announcement is not defined as a "personnel action" under §2302 (a), even if Mr. Hawkins intended to retaliate, this action would not constitute a prohibited personnel action. With respect to the new position, ***(b)(6)*** was a GS-11 and would not be eligible for promotion to a GS-13 position. Because ***(b)(6)*** retired after the announcement was cancelled and indicated in her testimony that she was not seeking any relief, we did not review the issues any further.

Conclusion

Several complainants raised issues of prohibited personnel practices in the selection of CAVHCS service chiefs made in 1997, including retaliation for whistleblowing and for cooperating in OIG reviews. We substantiated that prohibited personnel practices had occurred in several of the selections. CAVHCS management knew or suspected that certain employees had complained to, or cooperated with, Congressman Everett, the OIG and/or the General Accounting Office about CAVHCS management at or about the

time of the service chief selections. CAVHCS management made public expressions of its unhappiness with the various complaints and investigations in the form of verbal remarks and written communications made prior to the service chief selections.

Management has been unable to adequately explain the reasons for its nonselections of the complainants. Having established protected activity which was known to management, motivation on the part of management to retaliate, and personnel actions against the complainants that cannot be defended as legitimate management actions, we conclude that prohibited personnel practices occurred in several of the selections of the CAVHCS service chief positions in 1997. We have referred our evidence concerning the incidences of preferential treatment, which also have race as a factor, for consideration to the VA ORM for review and disposition.

Recommendation 4

The Director, VISN 7 should:

a. Take appropriate administrative action as to CAVHCS Director Mr. Jimmie Clay's prohibited personnel practices.

b. Take appropriate administrative action as to CAVHCS Associate Director Mr. John Hawkins' prohibited personnel practices.

c. Take appropriate administrative action to correct · ***(b)(6)*** · · · · · · · · · · · · · · · · · · nonselection as CAVHCS · ***(b)(6)*** · · · · · · · · · · .

d. Take appropriate administrative action to correct · ***(b)(6)*** · · · · · · · · · · · · · · · · · nonselection as CAVHCS · ***(b)(6)*** · · · · · · · · · · · · .

e. Take appropriate administrative action to correct · ***(b)(6)*** · · · · · · · · · · · · · · · · · nonselection as CAVHCS · ***(b)(6)*** · .

f. Take appropriate administrative action to correct · ***(b)(6)*** · · · · · · · · · · · · · · · · · · nonselection as CAVHCS · ***(b)(6)*** · · · · · · · · · · · · · .

g. Take appropriate administrative action to correct personnel actions relating to · ***(b)(6)*** · · · · · · · · · · · · · 's duties and responsibilities.

VHA Comments

The Chief Network Officer concurred with recommendations 4.b., 4.c., and 4.d., and noted that appropriate action would be proposed against Mr. Hawkins for engaging in prohibited personnel practices, and that action would be taken to correct · ***(b)(6)*** · · · · · · · · · · · s non-selection as CAVHCS · ***(b)(6)*** · · · · · · · · · · and · ***(b)(6)*** · · · · · · · · s non-selection as CAVHCS · ***(b)(6)*** · · · · · · · · · · · · · . The Chief Network Officer's complete comments are in Appendix B. The Chief Network Officer did not concur with recommendations 4.a., 4.e.,

4.f., and 4.g. His complete comments on these recommendations are provided below and in Appendix B.

Regarding recommendation 4.a., the Chief Network Officer stated:

Mr. Clay's lack of knowledge and failure to be actively involved in the selection of key medical center managers represents performance below that which would be expected of VHA senior managers. A medical center director would normally be expected to follow closely the process of selection and, if not actively involved, at least be familiar with the candidates and the process of selection. However, there is a problematic evidentiary question as to the level of Mr. Clay's involvement in the actual selection and selection process, and thus whether his actions rise to the level anticipated by 5 U.S.C. 2302(b). Mr. Clay delegated the selection of the service chiefs to Mr. Hawkins and by all appearances deferred to Mr. Hawkins' decision in making those selections. We find nothing evidencing that Mr. Clay reviewed the applications or was otherwise aware of the comparative qualifications of the candidates. There is also a dearth of evidence that his approval was no more than a mere concurrence in the selections made by Mr. Hawkins or that his action was based on reasons other than those cited in Mr. Hawkins' selection memorandum. It is anticipated that this insulation from the actual selection process and decision would be asserted in defense of any related disciplinary action against him. Although there is room for debate, weighing this factor as a trial consideration, it is concluded that such a defense could seriously jeopardize the agency's ability to support a disciplinary action based on prohibited personnel practice for non-selection.

Although OIG indicates disclosures/cooperation and knowledge at or about the time of the service chiefs' selections, discussion in support of the recommendation does not include dates or relative time frames which support that conclusion. For example, several statements by Mr. Clay, which were relied upon to evidence his knowledge of certain disclosures, were made in interviews several months after the selections. Such statements, therefore, do not conclusively show that he had such knowledge at the time he concurred in Mr. Hawkins' selections. Without specific facts showing the requisite time frames, it is not possible to properly evaluate whether the disclosures and/or cooperation, and Mr. Clay's knowledge, predated any approval action and could, therefore, serve as an evidentiary basis for a retaliatory motive.

Additionally, for some of the non-selectees, there is insufficient evidence of any disclosure or cooperation with OIG or of Mr. Clay's knowledge of same. For example, it is conceded by OIG that ***(b)(6)*** has not claimed to have made any complaints to OIG or to Congressman Everett. It is stated that he cooperated with OIG, but such cooperation alone is not sufficient to evidence the requisite disclosure or cooperation or to indicate a motive for retaliation. Numerous employees, including selectees ***(b)(6)*** and ***(b)(6)***, cooperated with and were interviewed by OIG. It further appears that ***(b)(6)*** was interviewed by OIG only a few days prior to the time Mr. Clay signed off on the selection. Moreover, there is no indication that at the time of the selection either Mr. Clay or Mr. Hawkins was personally

aware that · ***(b)(6)*** · · · · · · · · · · was being interviewed or of what information he might be providing to OIG.

Unless it can be shown that Mr. Clay was aware of the noted irregularities in the screening panel's scoring, the fact that · ***(b)(6)*** · · · · · · · · · · did not rank among the top three candidates appears to be a legitimate basis for his non-selection. Not being one of the top three, the significant factor test would not be met because it is unlikely that Mr. Clay would have had any reason to override the recommendation of the screening panel and Mr. Hawkins' selection in favor of · ***(b)(6)*** · · · · · · · · · ..

There is also neither direct nor sufficient circumstantial evidence that Mr. Clay had knowledge of any disclosures made by · ***(b)(6)*** · · · · · · · · · or that his cooperation with the OIG investigation was in any way different from that of numerous other CAVHCS employees who cooperated by responding to OIG inquiries. There is also some indication that · ***(b)(6)*** · · · · · · · may not have been interviewed by OIG until more than two months after his non-selection for the Chief, · ***(b)(6)*** · position. The only other evidence presented is · ***(b)(6)*** · · · · · · · · · knowledge of · ***(b)(6)*** · · · · · · · · · cooperation with OIG in a criminal investigation. There is no indication that · ***(b)(6)*** · · · · · · · · communicated this information to Mr. Clay or that it could otherwise be imputed to him.

Based on our review, VHA concludes that Mr. Clay did not involve himself in the selection of these key management officials in any meaningful way. In delegating the selection to Mr. Hawkins and relying on his input almost exclusively, he served to inappropriately insulate himself from the selection process. While VHA does not believe that the facts meet the requirements of a prohibited personnel practice on the part of Mr. Clay, we do conclude that it constitutes poor management for which appropriate administrative action will be taken.

Regarding recommendations 4.e., 4.f., and 4.g., the Chief Network Officer stated:

For several of the employees identified by OIG, the evidence is insufficient to insure that the agency could meet its burden of proof in any appeal of a disciplinary action based on alleged prohibited personnel practice under 5 U.S.C. 2302(b)(8) or 2302(b)(9). To meet its burden the agency must prove by a preponderance of the evidence that: (1) the acting official (Clay/Hawkins) has the authority to take, recommend, or approve any personnel action; (2) the aggrieved employee made a disclosure protected under section 2302(b)(8) or cooperated with OIG pursuant to section 2302(b)(9); (3) the acting official used his authority to take, or refuse to take, a personnel action against the aggrieved employee; and (4) the acting official took, or failed to take, the personnel action against the aggrieved employee because of the protected disclosure. Inherent in this last element is the requirement that the acting official have knowledge of the disclosure. The difficulties of proving the alleged incidents of prohibited personnel practice primarily involve the nature and specificity of the disclosure or cooperation with OIG; the knowledge of any such disclosure by Mr. Hawkins or Mr. Clay; and whether that knowledge was a significant factor in the personnel action in question. A "significant factor" is one based on improper motive

and one that plays an important role in the alleged retaliatory action. If an appellant shows that he would have taken the personnel action absent the protected disclosure, the "significant factor" test is not met. *Gores v. Department of Veterarns Affairs*, 68 M.S.P.R. 100, 114 (1995).

Unless it can be shown that · ***(b)(6)*** ·····s non-selection was the result of a violation of 5 U.S.C. 2302(b)(8) or 2302(b)(9), there is no basis for taking corrective action. As outlined in the response to Recommendation 4 a., evidence of the knowledge and time elements necessary to substantiate such a violation have not been established.

Unless it can be shown that · ***(b)(6)*** ·····s non-selection resulted from a violation of 5 U.S.C. 2302(b)(8) or 2302(b)(9), there is no basis for taking the proposed administrative action. As outlined in the response to Recommendation 4. a., evidence sufficient to prove such a violation has not been established.

The VHA Investigative Team did not find the requisite improper motive arising from allegations which · ***(b)(6)*** ·····brought to the CAVHCS management concerning · ***(b)(6)*** ····· or from his cooperation in the ensuing OIG investigation of those allegations. It is further noted that there is an absence of definitive time frames to support an assumption of retaliatory motive related to these or other alleged disclosures.

As evidence of a retaliatory motive, it is stated that the changes in · ***(b)(6)*** ····· duties contravened instructions from VISN not to take action affecting any of the employees who had complained to the OIG about the selection process. It is reasonable to assume that such instructions applied only to those displaced chiefs who had complained of their non-selections. · ***(b)(6)*** ·····was not included in that group and no evidence is cited to show how he would come within the scope of those instructions.

In defense of an allegation of retaliatory motive, the facts provide some rationale basis for the consolidation of the services and for the selection of · ***(b)(6)*** ·····as the chief of the combined service. There is evidence that the consolidation of these services had been under consideration for some length of time and that Mr. Clay had directed a special study to look at consolidating the two services. He also articulated several performance-based problems with · ***(b)(6)*** ·····and that the effectiveness of the · ***(b)(6)*** ·····Services had been hampered by the lack of an effective relationship between · ***(b)(6)*** ·····and the former chief of · ***(b)(6)*** ·····Service, · ***(b)(6)*** ·····. Furthermore, there seems to be a legitimate basis for filling the · ***(b)(6)*** ····· chief's position with · ***(b)(6)*** ·····, who was a displaced GS-13 supervisor, as opposed to · ***(b)(6)*** ·····, a GS-12.

For the foregoing reasons, it is concluded that there is insufficient evidence of a prohibited personnel practice with regard to · ***(b)(6)*** ·····. Without such evidence there is no justification for taking corrective actions related to his duties and responsibilities.

OIG Response

We consider the Chief Network Officer's comments regarding recommendations 4.b., 4.c., and 4.d. to be responsive and will follow up to ensure the planned actions are taken.

Regarding recommendation 4.a.:

We do not agree with the Chief Network Officer's comments pertaining to recommendation 4.a. VHA's position that Mr. Clay cannot be charged for engaging in a prohibited personnel practice, i.e., retaliation against employees for engaging in protected activities, is based on VHA's contention that insufficient evidence exists to show Mr. Clay was involved in the selection process; and/or, that there was insufficient information that Mr. Clay knew of the protected activities prior to the selections. In our view, there is sufficient evidence for VA to sustain charges against Mr. Clay for retaliating against one or more of these employees when they were non-selected for the integrated chief positions. First, contrary to VHA's assertion, Mr. Clay had knowledge or suspected, prior to the non-selections or other personnel actions, that one or more of these employees engaged in protected activities. In addition, his animus towards these employees was clearly evident in his statements to the OIG and in public prior to the early November 1997 selection of the integrated service chief positions, all of which were included in our report and/or made available to VHA's review team. As evidence of Mr. Clay's knowledge that · ***(b)(6)*** · · · · · · · · · · was a whistleblower prior to the selection of the service chiefs, Mr. Clay appeared on a local television program on June 15, 1997, "Russo on the Spot," in which he stated:

> "This allegation was made by 2 or maybe 3 people. One has been made known to me. This was a white male who was not selected for a position at the West Campus. I selected the best qualified individual; a black female and I still stand by the decision. Following that decision, by the way, these questions and concerns about the mismanagement escalated. So I associate with this particular allegation."

Although Mr. Clay does not mention · ***(b)(6)*** · · · · · · · · · · by name, we are not aware of any other individual that Mr. Clay could have been referring to when he made this statement on June 15, 1997, more than 5 months prior to the nonselection of · ***(b)(6)*** · · · · · · · · · ..

Further evidence of Mr. Clay's knowledge, prior to the selections, that · ***(b)(6)*** · · · · · · · · · · made protected disclosures, and his animus toward · ***(b)(6)*** · · · · · · · · · · ,· is found in Mr. Clay's October 27, 1997, testimony to the OIG. In his testimony, which was taken under oath and recorded, Mr. Clay was asked about statements he had made to the OIG in an unrecorded briefing that occurred the previous day. Mr. Clay confirmed that he had given the OIG the impression, on October 26, that he believed that · ***(b)(6)*** · · · · · · · ·

· · · · was a significant force behind a number of allegations and problems that had been brought to the OIG's attention. Mr. Clay further stated:

> "I understand that · ***(b)(6)*** · · · · · · · · · · ,· by the way, has told people that he had provided information to Congressman's office and also to the IG, and this is what he told some people that have, by the way, shared that information with me….He [· ***(b)(6)*** · · · · · ·] has filed an EEO complaint by the fact that he was not selected for one of the managerial positions [· ***(b)(6)*** · · · · · · · · · · · · · · · · · ·]· of which I was the selecting official, by the way, and when · ***(b)(6)*** · · · · · · · was here, in the town hall meeting he had, · ***(b)(6)*** · · · · · · · · · · asked a question that gave · ***(b)(6)*** · · · · · · · the impression that he was one of the people that was providing information to the Congressman's office."

Although it is unclear when this particular town hall meeting was held, it had to be more than two months prior to Mr. Clay's testimony, because · ***(b)(6)*** · · · · · · · retired from VA sometime in mid-August, 1997. In addition to having knowledge, or at least suspecting, that · ***(b)(6)*** · · · · · · · · · · was the source of complaints or allegations, Mr. Clay also made statements during his June 15, 1997, appearance on the local cable television show and in his October 27, 1997, interview with the OIG clearly indicating that he took the complaints raised to Congressman Everett as a personal attack, which would indicate a motive to retaliate. In addition, Mr. Clay made similar statements in his testimony to the VHA review team.

Second, there is ample evidence to show that Mr. Clay was involved in, not isolated from, the selection process. Mr. Clay testified both to the OIG, to the Office of Resolution Management, and to the VHA review team that he was involved in selecting the panel and the method for rating and ranking the applicants, including having the union on the panel as full participating members. He also reviewed the selection files, had discussions with Mr. Hawkins before he approved the selections, and had discussions with the VISN Director when he recommended that the VISN Director approve the selections. Transcripts of Mr. Clay's testimony regarding this issue were provided to the VHA review team. The fact that Mr. Clay was involved, or represented that he was involved, in the selection process is also evidenced in the testimony provided by the VISN Director which was also made available to the review team. In addition, · ***(b)(6)*** · · · · · · · · ,· · ***(b)(6)*** · ,· testified in a statement to the OIG that Mr. Clay and Mr. Hawkins communicated regularly and frequently, and if Mr. Hawkins made a decision, "then he would go back and inform Mr. Clay of what has transpired…." As a final point on this issue, although interviewed on more than one occasion regarding these selections, Mr. Clay never asserted that he was not involved in the selection process.

Third, VHA attempts to exonerate Mr. Clay on the charge that he retaliated against one or more of the complainants for engaging in protected activities by attributing his decision not to select these employees to his being a poor manager. Although we do not disagree with the conclusion that Mr. Clay was a poor manager, there is sufficient

evidence to prove that the decision not to select these individuals was in retaliation for making protected disclosures.

If Mr. Clay were charged with retaliation against employees for engaging in protected activities, the agency would have to prove by a preponderance of the evidence that whistleblowing was a significant factor in the personnel action. In addition to the evidence of knowledge, timing and motive as detailed in our report, the fact that Mr. Clay has not offered a reasonable explanation for not selecting these employees further supports that the whistleblowing was a significant factor in the nonselections. Though he has been provided ample opportunity to provide a reasonable explanation for the nonselections, Mr. Clay has not done so. The evidence shows that (1) Mr. Clay was aware that none of the service chiefs he knew or suspected were engaging in protected activities were selected for the integrated service chief positions; (2) Mr. Clay made numerous statements both before and after the selections which clearly demonstrated an animus towards the individuals who went to Congressman Everett and/or the OIG, and, in particular, · ***(b)(6)*** and · ***(b)(6)***; (3) unlike Mr. Hawkins, who had only been at CAVHCS for several months, Mr. Clay was familiar with the work of each of these employees and was the approving official for highly successful and outstanding performance ratings for many of the employees who alleged retaliation; (4) Mr. Clay was not familiar with the capabilities of any of the non-CAVHCS employees selected for these positions yet chose to approve and recommend their selections to the VISN Director without conducting a further review; and, (5) Mr. Clay has not offered any reasonable explanation regarding why these employees were not selected. Clearly, these facts considered, there is ample evidence that engaging in protected activities was a significant factor in Mr. Clay's decision to approve and recommend the non-selection of these employees for integrated service chief positions, particularly · ***(b)(6)*** and · ***(b)(6)***.

We note that VHA's response to recommendation 4.a. limited its discussion only to issues relating to the non-selection of · ***(b)(6)*** and · ***(b)(6)***, and did not address the non-selection of · ***(b)(6)*** and · ***(b)(6)***, the two employees who Mr. Clay demonstrated the most animus towards both before and after the selections were made, and the two employees that VHA already agreed were retaliated against by Mr. Hawkins. While we may agree it would be more difficult to meet the standard of proof required to sustain a disciplinary action against Mr. Clay for the non-selection of · ***(b)(6)*** and · ***(b)(6)***, we firmly believe that ample evidence exists to support such an action against Mr. Clay for the non-selection of · ***(b)(6)*** and · ***(b)(6)***.

With respect to the non-selection of · ***(b)(6)*** and · ***(b)(6)***, VHA's response suggests a misunderstanding regarding the facts and evidence in the OIG files. As an example, when discussing · ***(b)(6)***s non-selection, VHA states that "there is some indication that · ***(b)(6)*** may not have been interviewed by OIG until more than two months after his non-selection for the Chief, · ***(b)(6)*** position." VHA further asserts that "the only other evidence presented is · ***(b)(6)***s knowledge of · ***(b)(6)***s cooperation with OIG criminal investigation. There is no indication that ·

(b)(6) communicated this information to Mr. Clay or that it could otherwise be imputed to him." First, several OIG reviews were in progress on a number of issues long before the selections were made for the integrated service chief positions and ***(b)(6)*** was interviewed during at least one of these reviews. VHA never raised this issue with the OIG during its review of the OIG files. Had the team raised the issue, they would have been provided evidence regarding ***(b)(6)***'s cooperation with the OIG. Second, the records clearly show that ***(b)(6)*** approached ***(b)(6)*** and other employees who were thought not to be "team players" at the request CAVHCS management, i.e., Mr. Clay and Mr. Hawkins, for the purpose of obtaining, for management, any information that was given to the OIG. The evidence supports a finding that ***(b)(6)*** was not only acting at the request of management, but also provided the information he obtained to management which would have provided management with knowledge or suspicions regarding which employees were providing information to the OIG.

We have referred this matter to the Deputy Secretary for resolution.

Regarding recommendations 4.e, 4.f., and 4.g.:

We do not agree with the Chief Network Officer's comments pertaining to recommendations 4.e., 4.f., and 4.g. VHA states that "the evidence is insufficient to insure that the agency could meet its burden of proof in any appeal of a **disciplinary action** based on alleged prohibited personnel practices under 5 U.S.C. § 2302(b)(8) or 2302(b)(9)." (Emphasis added). VHA explains the elements that must be proven to sustain such an action, including whether "knowledge [of a protected disclosure] was a significant factor in the personnel action in question." This argument, however, is erroneous because our recommendations relate to **corrective action** on behalf of ***(b)(6)***, ***(b)(6)*** and ***(b)(6)***, not disciplinary action. We agree that to sustain a disciplinary action the agency must prove that the protected activity was a significant factor in the decision to take or not take a personnel action. However, the complainant in a corrective action case, whether it is the aggrieved employee or the Office of Special Counsel on behalf of the employee, only needs to prove by a preponderance of the evidence that the protected activity was a "contributing factor."

VHA does not present sufficient evidence to support its conclusion that actions taken, or not taken, against ***(b)(6)***, ***(b)(6)*** and ***(b)(6)*** were not retaliation for engaging in protected activities. This is disturbing because investigations by two independent entities, the OIG and an investigator hired by the VA Office of Resolution Management, concluded otherwise. We understand that ***(b)(6)*** and ***(b)(6)*** have retained counsel who recently filed complaints on their behalf with the Office of Special Counsel. The Office of Special Counsel will either bring an action on their behalf or decline, thus allowing them to file an Independent Right of Action directly with the Merit Systems Protection Board.

VHA's arguments regarding ***(b)(6)*** are disturbing for several reasons. First, VHA's response only addresses CAVHCS management's decision to combine ***(b)(6)***

. . . . . Services and reassign . ***(b)(6)*** . . . . . as the Chief. Our report concluded that this was not a prohibited personnel action as defined by § 2302(a)(2)(A). Rather, we recommended VHA review the actions taken against . ***(b)(6)*** . . . . . after the services were merged. There is no evidence that VHA reviewed these issues. VHA's argument that the "absence of definitive time frames to support an assumption of retaliatory motive related to these or other alleged disclosures" has no basis in fact, particularly regarding the issue of . ***(b)(6)*** . . . . . change in duties. The change in duties occurred after the OIG began its investigation of complaints that certain employees were not selected for integrated service chief positions. It is clear from the transcripts of the interviews with both Mr. Clay and Mr. Hawkins that the OIG was reviewing a complaint from . ***(b)(6)*** . . . . . It is also clear from statements by Mr. Clay and Mr. Hawkins before . ***(b)(6)*** . . . . . 's duties were changed, that they expressed animus towards employees who went to the Congress, the OIG or another outside entity with complaints against CAVHCS management. Accordingly, VHA's statement that there is insufficient evidence of knowledge and timing to support a corrective action is inconsistent with the evidence. VHA's reliance on statements by Mr. Clay regarding the effectiveness of . ***(b)(6)*** . . . . . Service under . ***(b)(6)*** . . . . . 's supervision, performance based problems with . ***(b)(6)*** . . . . . , and the lack of an effective relationship between . ***(b)(6)*** . . . . . and the former Chief, . ***(b)(6)*** . . . . . Service, further suggests VHA's misunderstanding concerning the evidence and issues in this case. Although, Mr. Clay's statement is inconsistent with other evidence, VHA did not reconcile these differences. For example, while there was a review of the problems between . ***(b)(6)*** . . . . . Service, the report shows that the reviewers attributed the problem more to the Chief, . ***(b)(6)*** . . . . . Service than to . ***(b)(6)*** . . . . . This conclusion was confirmed by the OIG in discussions with one of the reviewers.

To preclude further delay on this issue, and to ensure that . ***(b)(6)*** . . . . . 's rights are fully protected, we have notified . ***(b)(6)*** . . . . . of our findings on his behalf and of his right to file a complaint with the Office of Special Counsel. If . ***(b)(6)*** . . . . . decides to pursue the issue with the Office of Special Counsel, his right to due process will be fully protected.

Issue 2: Human Resources Management Technical Review

The Office of Deputy Assistant Secretary for Human Resources Management (HRM) in VA Central Office assigned two HRM professionals to work with our office in this inquiry. We also had the assistance of a VHA HRM manager who participated in the integration of two other Medical Centers. The HRM team reviewed the staffing of several positions for compliance with applicable laws, regulations, VA and CAVHCS policies. The positions reviewed included the ***(b)(6)***, ***(b)(6)***, Chief, ***(b)(6)*** Service (***(b)(6)***), Chief ***(b)(6)*** Service, ***(b)(6)***, and three patient ombudsman positions. HRM staff also examined three paysetting actions that came to their attention during the review.

The HRM team found numerous regulatory and procedural violations. Some of the violations are so significant that the new selectees will have to be displaced. Others can be resolved with lesser actions. Because of the volume and seriousness of the violations, we believe an outside HRM professional will need to be assigned to CAVHCS on a temporary basis until corrective actions are completed. Additionally, current local human resources staff will require thorough training in classification, staffing, Reduction-in-Force (RIF) and pay setting policies and procedures. Finally, the new Human Resources Manager should develop and implement clear quality management reviews and standards to preclude repeated violations such as were found in this report.

Administrative Manager Positions

While the review team found no merit promotion violations in the staffing of the five administrative manager positions, they identified several regulatory and procedural violations. The team also found that several employees were displaced when applicants from outside the CAVHCS were selected for the positions, with no effective placement planning for the displaced employees.

Classification Results

Federal regulations require that a valid position classification action occur before an employee is assigned to a position.[11] The team did not find classified positions in all cases before the administrative managers were assigned to their CAVHCS positions. The following regulatory and procedural violations must be corrected.

(b)(6)

The ***(b)(6)*** job was properly classified in June 1997 as an ***(b)(6)*** position, GS-***(b)(6)***-13. The approved position description, however, was not used to announce the position. Instead, the position was advertised as ***(b)(6)*** position, GS-***(b)(6)***-12/13 or 13. ***(b)(6)*** was assigned to the ***(b)(6)***

[11] OPM Guide for Processing Personnel Actions, Chapters 3 and 4.

position on a Standard Form (SF) 50-B noting the position as a · ***(b)(6)*** ·, GS-· ***(b)(6)*** · -13. This discrepancy needs to be resolved.

· ***(b)(6)*** · · · · · · · · · · · · · ·

The · ***(b)(6)*** · · · · · · · · · · · · · ·job was properly classified in June 1997 as a · ***(b)(6)*** · · · · · · · · · · · · · · position, GS-· ***(b)(6)*** -13. There was a corresponding position description, number 1666. The vacancy announcement reflected that classification. The selectee, · ***(b)(6)*** · · · · · · · , was assigned to the position using a SF 50-B to the appropriate title, series, and grade, but the position description number was incorrectly noted as number 000000. This regulatory violation needs to be corrected.

Chief, · ***(b)(6)*** ·

The HRM team found no classified position description for the Chief, · ***(b)(6)*** · position at CAVHCS. Yet, the position was announced and filled which constituted a regulatory violation. · ***(b)(6)*** · · · · · · was selected, but management improperly assigned him to the position of Chief, · ***(b)(6)*** · Tuskegee, because there was no classified position description for the integrated position. The assignment was also improper because another person already encumbered the position.

· ***(b)(6)*** · · · · · · is currently filling a position description that does not correctly describe the responsibilities of the CAVHCS manager for both campuses. Action needs to be taken to resolve the regulatory violation of announcing and selecting for a position without a classified position. Management also needed to resolve the dual incumbency of the position, which was eventually accomplished after this review.

Chief, · ***(b)(6)*** · *Service*

The · ***(b)(6)*** · position was cancelled. Mr. Hawkins combined the function with the · ***(b)(6)*** · · · · · · · · · · · · · · · · Service to create the new position of Chief, · ***(b)(6)*** · Service. · ***(b)(6)*** · · · · · · · , the former · ***(b)(6)*** · · · · · · · · · · · , · · ***(b)(6)*** · · · · · · · · Service, was reassigned to this new position on November 9, 1997. The VA personnel computer system would not accept the position title. · ***(b)(6)*** · · · · · · · · was reassigned as Chief, 33 days before the position was actually classified on December 12, 1997. At the time of our review, the regulatory violation had not been corrected.

· ***(b)(6)*** · · · · · · · · · · · · · · ·

This position was properly classified and there were no discrepancies in the title, series, and grade of this position or on the SF 50-B assigning · ***(b)(6)*** · · · · · · · · to the position. There were no regulatory or procedural violations noted.

Employee Displacement Results

At the time the administrative manager positions were announced in August 1997, CAVHCS had several incumbents in facility manager positions at the GS-13 grade level: Chief, · ***(b)(6)*** · · · Service (2); Chief, · ***(b)(6)*** · · · · · · · · Service (1); and, Chief, · ***(b)(6)*** · · (1).

Mr. Hawkins and Mr. Clay said they planned to ensure that any displaced service chiefs were not downgraded. The CAVHCS Human Resources Manager told us that, if necessary to retain the grades of those affected by the reorganization, she would classify their positions as "incumbent-only." That is, if positions in the new organization were lower than any incumbent held prior to integration, the position descriptions would not reflect the lower grade. Rather, each would be annotated to show that as long as the first incumbent held the position, the grade of the position would not be lowered. Such intentional over-grading of a position would violate Federal law.[12]

Other than the stated intention to retain pre-integration grades, we found no plans for orderly transition to the new integrated health care system if managers from outside CAVHCS were selected for the new managerial positions, as eventually happened. In spring 1997, the · ***(b)(6)*** · · · · · · · · (West Campus) and Mr. Clay exchanged memorandums about what would happen if internal candidates were not placed in the positions. Although the correspondence referenced the RIF implications, the contents of Mr. Clay's responses do not show an understanding of the RIF implications.

The VAMC Atlanta provided CAVHCS HRM support in recruiting and staffing the positions. The Atlanta Chief, HRMS told us he had conversations with Mr. Clay about what would happen to incumbents if not selected for the new positions. The Atlanta Chief said he did not think that Mr. Clay understood the RIF implications of the actions. He said because of his concern about Mr. Clay's lack of understanding, he also talked with · ***(b)(6)*** · · · · · · · · about the RIF implications. In recent testimony to the OIG, · ***(b)(6)*** · · · · · · · · showed a significant lack of understanding about RIF rules. We also found at the time of our review that there were still no new position descriptions for the displaced former service chiefs.

Patient Ombudsman Positions

The HRM team found numerous regulatory and procedural violations in the staffing of the three patient ombudsman positions, including ten candidates whose applications were rated and ranked but were not considered for promotion. Also, one employee who did not file a timely application was referred for promotion without a rating and ranking of her application.

Numerous other employees were improperly referred for consideration for noncompetitive reassignment even though they were not eligible for noncompetitive reassignment. Two of the applicants referred for promotion to the GS-7 level were

[12] 5 U.S.C. 5106 and 5107.

given competitive advantages not given other employees, although neither of these applicants was selected for the position. These and other actions caused the HRM team to rule that management violated Title 5, Code of Federal Regulations, Section 511.701(a), and that the three ombudsman selections should be cancelled.

In July 1997, CAVHCS announced the patient ombudsman positions at the GS-5/7/9 grade levels, with a target grade of GS-9. Over 100 employees from the 2 campuses applied. CAVHCS HRMS convened a promotion panel to rate the applications. The panel only rated the applications for promotion to the GS-7 level. Candidates for reassignment to the GS-7 level were not rated, nor were candidates for reassignment or promotion to the GS-5 or 9 levels.

On August 19, 1997, HRMS referred 100 candidates to the selecting official, Mr. Hawkins. The 100 applicants were on 7 selection certificates, including separate certificates for reassignment and promotion to GS-5, 7 and 9 and one for change to lower grade to GS-5. Mr. Hawkins selected three applicants for promotion. The selectees were promoted to GS-7 patient ombudsmen on October 12, 1997.

The HRM team and OIG found numerous regulatory violations in the patient ombudsman staffing process. Following are the most serious of those violations.

- The promotion panel established a cutoff score of 77. That is, all candidates rated 77 or higher were to be referred to the selecting official. One candidate with a score of 72 and a second candidate who was not rated by the panel was referred on the selection certificate. Mr. Hawkins did not select either of the improperly referred candidates. Nonetheless, they were both considered for the position, while 10 other candidates with scores between 72 and 76 were not considered because their names were not on the certificate.

- The seven candidates referred for reassignment to the GS-7 level were not rated and ranked by the promotion panel. VA policy[13] requires that the list of best-qualified applicants be a combined list. The list must include promotion candidates along with reassignment (or demotion) candidates who are competing for a position with higher promotion potential. In this case, the candidates competing for reassignment and promotion were competing at the GS-7 level for a job with promotion potential to the GS-9 level. That is, if they were selected at the GS-7 level, they could be noncompetitively promoted to the GS-9 level when ready without further competition. Thus, all the candidates should all have been rated and ranked by the promotion panel, and the best qualified of the combined group should have been referred on a single selection certificate.

- The promotion panel rated one candidate a score of 67. The candidate fell below the panel's cutoff score of 77 and was thus not referred on the GS-7 promotion list and not eligible for promotion to the GS-7 level in this case. However, because

[13] MP-5, Part I, Chapter 335, C.11.a.(1)

HRMS referred all candidates for reassignment, the candidate was referred for reassignment at her then-current grade, GS-5. However, Mr. Hawkins selected her for promotion to GS-7. HRMS did not catch his error. The candidate with a score of 67 was thus promoted to the GS-7 level in violation of federal regulations and VA merit promotion policy.

- Employees were promoted to GS-7, but no GS-7 classified position existed. Additionally, the classification of the GS-9 level position description, which could have been used as a basis for the GS-7 position, was never finalized. Assignment of employees to unclassified, nonexistent positions violates Federal regulations[14] and requires cancellation of the actions.

- We also found that Mr. Hawkins selected three African-American females, and never interviewed anyone for the positions that gave rise to employee complaints of discrimination and unfair treatment. These EEO complaints are now the subject of an independent review by the newly appointed VA Office of Resolution Management staff.

Paysetting Actions

We found that improper paysetting actions occurred on three assignments to CAVHCS. These actions resulted in incorrect pay rates for Mr. Hawkins, · ***(b)(6)*** · · · · · · · · · · · · · · · · · and · ***(b)(6)*** · · · · · · · · · · · ·.·

For Mr. Hawkins and · ***(b)(6)*** · · · · · · · · ·, the incorrect rates are related to the locality pay rules. It appears that basic pay plus locality pay earned in the prior position was used to set basic pay in the new CAVHCS position. This is inappropriate because locality pay is not "portable," i.e., it does not move with an employee when the employee relocates to a new locality. If done properly, only basic pay earned in the prior position would have been used to set basic pay for the new CAVHCS position, and then locality pay for the new locality would be added. Correction of the actions will result in a pay reduction for Mr. Hawkins of approximately $2,400 a year and for · ***(b)(6)*** · · · · · · · · ·of approximately $1,500 a year.

CAVHCS granted · ***(b)(6)*** · · · · · pay retention for the GM-13 salary he was earning at his previous duty station. His CAVHCS position is a GS-12. When setting his CAVHCS pay, it appears the HRMS staff neglected to adjust · ***(b)(6)*** · · · · ·' pay for the move from the GM to the GS pay system. Correction of the action will result in a pay increase for · ***(b)(6)*** · · · · · of approximately $250 a year.

The required paysetting actions for · ***(b)(6)*** · · · · · · · · · · · · ·, Mr. John Hawkins, and · ***(b)(6)*** · · · · · · · · · · · are shown on the following tables.

[14] 5 C.F.R. 511.701(a)

Required Paysetting Actions [15]

·(b)(6)· · · · · · · · · · ·	From: VAMC Ann Arbor, MI	To: CAVHCS
Actual Authorized:	GS-13, Step 1	GS-12, Step 8
Basic Pay	$51,003	$52,900
Locality Adjustment	$2,453	$2,544
Adjusted Basic Pay	$53,456	$55,444
Upon Correction:	GS-13, Step 1	GS-12, Step 7
Basic Pay	$51,003	$51,470
Locality Adjustment	$2,453	$2,476
Adjusted Basic Pay	$53,456	$53,946

John Hawkins	From: VAMC Saginaw, MI	To: CAVHCS
Actual Authorized:	GM-14, Step 00	GS-15, Step 6
Basic Pay	$75,339	$82,709
Locality Adjustment	$3,624	$3,978
Adjusted Basic Pay	$78,963	$86,687
Upon Correction:	GM-14, Step 00	GS-15, Step 5
Basic Pay	$75,339	$80,346
Locality Adjustment	$3,624	$3,865
Adjusted Basic Pay	$78,963	$84,211

·(b)(6)· · · · · · · · ·	From: VAMC North Chicago, IL	To: CAVHCS
Actual Authorized:	GM-13, Step 00	GS-12, Step 00
Basic Pay	$66,063	$66,063
Locality Adjustment	$5,371	$3,178
Adjusted Basic Pay	$71,434	$69,241
Upon Correction:	GM-13, Step 00	GS-12, Step 10
Basic Pay	$66,063	$66,303
Locality Adjustment	$5,371	$3,189
Adjusted Basic Pay	$71,434	$69,492

During interviews we learned that there were other 'save pay' actions taken for employees · ***(b)(6)***· · · · · · · · · · · ,·and · ***(b)(6)***· · · · · · · · · · .· Action should be taken to ensure that no discrepancies exist for these employees given the number of violations identified by the HRM team.

Conclusion

The HRM staff accompanying the OIG team concluded that valid position classification actions were not always taken before the administrative managers for CAVHCS were assigned to the positions. In addition, the advertising of the integrated administrative

[15] The 1997 pay rates are used to show the needed corrective actions because these rates were in effect at the time of the errors to ·***(b)(6)***· · · · · · · · · · and Mr. Hawkins' salary. The actions are in accordance with 5 C.F.R. 531.203, and MP-5, Part I, Chapter 531, Section B.

manager positions nation-wide created the possibility that CAVHCS employees would be displaced from their service chief positions. Mr. Clay and Mr. Hawkins did not want any employee downgraded as a result of any external selections. However, the way the new CAVHCS Human Resources Manager intended to implement that goal was through establishment of "incumbent-only" positions. Such positions would be in violation of Federal law. CAVHCS management should have considered the potential RIF implications of the staffing processes before any positions were filled.

Numerous regulatory and procedural violations occurred in the staffing of three patient ombudsman positions. Applicants that were rated below the cut-off score, or were not rated at all, were improperly referred for selection consideration. In one of these instances, the applicant was selected for promotion even though she was determined not to be qualified for the job. Selectees were also promoted to positions that were not classified, which is a regulatory violation.

The CAVHCS workforce should be able to depend on their human resources professionals. Yet, many of the regulatory violations we found in this review are so significant the only appropriate corrective action is removing the selectees from the positions. Others require reduction of employees' salaries. We can think of few actions that can affect employee morale and breed employee distrust more quickly and more severely than displacement and pay cuts. Although we have outlined numerous individual corrective actions, VHA managers should not lose track of a bigger implication: the CAVHCS human resources staff needs to be trained in classification, staffing and pay-setting, as a minimum, and then held to high quality standards that employees can rely on.

Recommendation 5

The CAVHCS Director, in conjunction with the Director, VISN 7, should:

a. Ensure all regulatory and procedural violations identified by the HRM component of this review are corrected.

b. Assign displaced CAVHCS managers to supportable GS-13 positions within the facility if they qualify for the assignments, and if not, follow Reduction-in-Force procedures to ensure employee rights are protected.

c. Cancel the October 1997 promotions of the three CAVHCS employees occupying the ombudsman positions.

d. If the positions are still warranted, finalize the classification of the GS-9 position description and prepare and classify a GS-7 position description. If candidates for the GS-5 level will be reviewed, classify a position description and develop a crediting plan for the GS-5 level.

e. If a decision is made to fill the positions, start the staffing process over or panel applications received in the previous staffing process and construct new selection certificates based on the panel results. In either case, ensure the actions are in full compliance with Federal regulations and VA and CAVHCS merit promotion requirements.

f. Retroactively adjust the salaries of the three managers as discussed in the report to reflect the correct amount that should be paid to these employees.

g. Initiate overpayment and collection actions and notify the employees of the intention to recoup the inappropriate amounts of salaries paid to them.

h. Ensure all other recent 'paysetting' actions were conducted in accordance with appropriate policies and procedures.

i. Seek the assistance of Human Resources professionals outside VISN 7 to work with the CAVHCS HRM staff in implementing the required corrective actions.

j. Ensure the CAVHCS human resources staff receives training in classification, staffing, and paysetting.

VHA Comments

The Chief Network Officer concurred with all of the above recommendations and noted corrective actions taken or planned. His complete comments are in Appendix B.

OIG Response

The Chief Network Officer's comments were responsive to our recommendations. We consider recommendations 5.d., 5.f., and 5.g. resolved, and will follow up on the remaining recommendations to ensure the planned corrective actions are taken.

PART IV

QUALITY OF HEALTH CARE

Issue 1: Appropriateness of Patient Care

We received allegations, which we substantiated, involving eight instances of inappropriate patient care at the East and West Campuses. We found that, in three cases, clinicians should have admitted West Campus patients for care sooner. We found that quality managers at both campuses had appropriately identified and reviewed most cases brought to OHI's attention, when the cases met the criteria for VHA's occurrence screening program. The occurrence screening process was generally well done except that clinical managers did not always aggressively follow findings related to issues of inappropriate physician performance.

Allegation 1: A patient had skin lesions that were not treated in a timely manner.

We substantiated this allegation. The attending physician identified and attempted to treat the skin rash, but there was more than a 1-month delay from the time the attending physician first asked for a dermatology consultation to the time the consultant examined the patient. Delayed responses to requests for a consultation resulted in the delay of a definitive diagnosis and initiation of appropriate treatment. We concluded that the attending physician and nursing staff should have been more aggressive in following up on the request for a dermatology consultation when there was no response to the first request. The patient eventually received appropriate treatment.

Allegation 2: An East Campus physician ordered medications for a patient without examining the patient or discussing the proposed medications with him.

We partially substantiated this allegation. We could not say with certainty whether the physician did or did not examine the patient. However, he did not adequately record his actions in the medical record.

The complainant alleged that on September 16, 1997, a psychiatrist ordered Haldol™ for an East Campus Nursing Home Care Unit patient without any basis for the treatment decision, and without examining him. The patient refused to take the medication, and the patient's attending physician discontinued the medication on the following day.

The patient's medical records show that the psychiatrist ordered the Haldol™ because ward employees reported that the patient had outbursts of verbal profanities. The psychiatrist also wrote that the patient was not amenable to counseling. The psychiatrist told us that he was the psychiatric consultant for the Nursing Home Care Unit and that he made twice-weekly rounds. He recalled speaking with the patient, insisting that he always speaks to his patients before he orders any treatment. He

agreed, however, that he did not clearly record, in the medical record, the conversation that he had with the patient.

An East Campus Administrative Board of Investigation reviewed this case. The Board determined that the patient's medical record documentation lacked clear information to substantiate that the psychiatrist actually saw the patient. East Campus staff appropriately addressed this issue after the OIG review.

Allegation 3: An East Campus patient was not diagnosed and treated properly for his epilepsy.

We substantiated this allegation. Clinicians transferred this patient to the East Campus from a private hospital for treatment of his seizures and multiple drug abuse on March 11, 1994. A complainant alleged that clinicians did not perform a definitive diagnostic evaluation even though the patient was in the hospital for 2 months. The complainant also alleged that clinicians inappropriately prescribed multiple anticonvulsant medications.

A consultant neurologist from VISN 5 reviewed the patient's medical record at our request. The consultant concluded that the patient's diagnostic evaluation was incomplete, and a neurologist apparently did not follow the patient's care.

The patient had canceled several appointments at the East Campus, and was last evaluated there on March 26, 1996. We gave the consultant's evaluation to the Acting Chief of Staff, who informed us that he gave it to the patient's primary physician, and had instructed the physician to follow up on the consultant's recommendations.

Allegation 4: A West Campus patient should have been admitted for definitive treatment on his first visit to the emergency room.

We substantiated this allegation. The patient, who had diabetes mellitus, hypertension, coronary artery disease, and a history of stroke, was seen in the West Campus outpatient clinic at 3:15 a.m. March 22, 1997. He had been short of breath since before midnight. Clinicians treated the patient, and his symptoms improved substantially. He was sent home at 4:30 a.m. and instructed to return to the West Campus at 7:30 a.m. for blood tests and a chest x-ray. The patient returned at 7:20 a.m., at which time he was reportedly groaning and moaning, but alert and responsive. His skin was pale and clammy. Clinicians administered oxygen and admitted him immediately to the Intensive Care Unit. He developed cardiopulmonary arrest before clinicians could transfer him to a bed. Clinicians attempted to resuscitate the patient, but he did not survive. The cause of death was myocardial infarction.

(b)(3) ***(b)(3)*** ***(b)(3)*** ***(b)(3)***

[redacted]

[redacted]

We could not say with certainty whether this patient would have survived if he had received definitive treatment earlier. OHI's physician, however, concluded that requesting this patient to return to the West Campus 3 hours after a night in the emergency room for laboratory studies represents both inadequate care and an unreasonable inconvenience to the patient and his family. The patient's blood work and chest x-ray should have been done when the patient initially came to the emergency room. These tests constitute essential elements of this patient's evaluation. The tests would have guided the admission decision. The OHI physician concluded that, based on available data, clinicians should have admitted the patient when he first came to the emergency room.

Allegation 5: A West Campus patient should have been admitted on his first visit to the emergency room.

We substantiated this allegation. A complainant alleged that a patient who was seen in the emergency room with significant abdominal distress should have been admitted for treatment but was not. On April 25, 1997, the patient came to the West Campus emergency room with a 5-day history of abdominal cramping, vomiting, and not eating. He admitted to drinking alcoholic beverages daily. Clinicians treated the patient with suppositories and over the counter medication, to be taken when needed. Clinicians planned for his primary care physician to follow the patient in 1 to 2 weeks. On April 27, the patient returned to the West Campus emergency room for the same problems with an additional symptom of hiccups. An X-ray of the abdomen showed a possible bowel obstruction and the patient was admitted. Clinicians transferred the patient to the VA Medical Center in Birmingham on April 30, 1997, for possible surgery.

Although this case may have been identified through the facility's Quality Management program, we found that the case was not reviewed. OHI's physician determined that the patient's emergency room care on his first visit was deficient in the following areas:

- Clinicians should have, but did not order appropriate laboratory studies (such as serum electrolytes, complete blood count, and urinalysis) that were warranted by the history and physical examination.

- Clinicians should have seriously considered obtaining abdominal films to explore a possible bowel obstruction. The results of these tests would have

resulted in a more reasoned and documented decision as to whether or not the patient should have been admitted.

- Clinicians should have performed a rectal examination.

- Clinicians should have admitted the patient to observe him closely.

Allegation 6: Emergency room physicians treated an elderly patient in ambulatory care even though he needed more aggressive care.

We substantiated this allegation. An 80-year-old patient was seen in the emergency room on three occasions before he was admitted. Emergency room notes for January 9, 1997 appear to indicate that the patient was already being treated with antibiotics, apparently for bronchitis. The January 11 emergency room notes indicate that clinicians prescribed additional antibiotics for the patient's pneumonia. Clinicians admitted the patient on January 13, 1997, and he died on January 19 of acute renal failure, possibly secondary to sepsis. The data and documentation in this case are incomplete. Nevertheless, OHI's physician did not believe that an 80-year-old patient with pneumonia should be treated with oral antibiotics on an outpatient basis. Even though the patient's ultimate death may not have been avoidable, it appeared that clinicians should have admitted this patient earlier.

Allegation 7: A West Campus patient allegedly died suddenly and without apparent explanation in the Intensive Care Unit as a result of inadequate care.

We substantiated this allegation. A complainant alleged that a West Campus Intensive Care Unit patient died suddenly, and that the circumstances surrounding his death needed to be investigated. We found that, contrary to the allegation, the case had been thoroughly reviewed by West Campus quality managers. The patient was seen in the West Campus emergency room at 7:30 p.m. on March 13, 1997. He told clinicians that he had shortness of breath and chest pain for the previous 1½ hours. The patient was pale and sweating. His pulse and respiratory rates were high. He gave a history of hypertension and insulin-dependent diabetes mellitus. Records show that the emergency room physician, the Medical Officer of the Day (MOD), examined the patient 5 minutes after he arrived, and promptly initiated therapy. The physician interpreted the electrocardiogram as representing a subendocardial myocardial infarction (heart attack). The patient was also diagnosed with pulmonary edema and diabetes mellitus, and was admitted. The patient arrived in the Intensive Care Unit at 8:00 p.m. The Intensive Care ***(b)(3)*** ***(b)(3)***

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West Campus managers instituted corrective actions to deal with all of the findings of the administrative investigation. However, they did not take any administrative action against the physician.

Allegation 8: An East Campus Nursing Home Care Unit patient died suddenly, when clinicians should have transferred the patient to an acute area unit.

We substantiated this allegation. An East Campus Nursing Home Care Unit patient had diagnoses of seizure disorder, stroke with left-side paralysis, hypertension, sickle cell anemia, and prostate cancer. He had been in the nursing home since September 18, 1996. His stay there was uneventful until September 30, 1997, at 5:40 p.m., when he started leaning to his left. He developed slurred speech. His hands started to shake, and he had difficulty breathing. The MOD examined the patient about 20 minutes after his symptoms began, and wrote a progress note indicating "no acute distress noted." The MOD also noted that the patient was somnolent and was snoring. He ordered Valium® 5 mg intramuscularly, which was administered at 6:00 p.m. At 6:40 p.m., a nurse called the MOD to the unit because the patient's abdomen was hard, his blood pressure had increased dramatically, and he was acutely short of breath. Nurses administered oxygen.

The MOD still concluded that the patient was not in acute distress, but that his prognosis was poor. He ordered another 5mg of Valium® and ordered that the patient be taken for an abdominal x-ray at 8:11 p.m. When the patient returned to the ward at 9:07 p.m., he was unresponsive. He quickly lost his vital signs, and a physician pronounced him dead at 9:46 p.m. The patient was in a "do not resuscitate" status; therefore clinicians did not attempt resuscitation.

This case was appropriately reviewed as part of the East Campus' Quality Management program. A physician reviewed the case as part of the occurrence screening program. ***(b)(3)*** ***(b)(3)*** ***(b)(3)*** ***(b)(3)*** ***(b)(3)*** Therefore, we did not make any recommendation in this case.

Unsubstantiated allegation

We did not substantiate the following allegation regarding inappropriate patient care:

- A complainant alleged that a physician inappropriately prescribed ampicillin for a patient even though he was also taking cafergot. The complainant alleged that this combination of drugs is lethal. According to the complainant, in 1993, the patient was taking cafergot, which a West Campus physician had prescribed, when an East Campus physician ordered ampicillin. We were unable to confirm that a physician

actually prescribed the ampicillin. Pharmacy records for 1993 transactions were archived and could not be located. Nevertheless, we concluded that the complainant's concerns were not well-founded. Ampicillin has been reported to increase the blood levels of cafergot and related ergotamine preparations, but the effect is not lethal, and the combined use of these two drugs is not necessarily contraindicated.

Conclusion

We substantiated eight of nine allegations that pertained to substandard clinical treatment. Most of the problems stemmed from failure to properly follow up on important clinical information. We found only one case in which quality managers had not identified and initiated evaluations of the salient factors in the case. They had properly identified and initiated reviews in the other serious issues. However, there were clear indications that managers did not initiate administrative actions with physicians when such actions appeared to be indicated.

Recommendation 6

The Director, CAVHCS, should:

a. Reduce the waiting time for dermatology consultations.

b. Ensure that physicians examine patients properly and clearly record their plans.

c. Ensure that clinicians completely record assessments and treatments with consideration of patients' rights to informed consent.

d. Ensure that the Chief of Staff follows up on a patient's epileptic status and procures proper neurological consultations.

e. Ensure that appropriate administrative action is taken for physicians whose care has been found to be deficient.

f. Systematically review patients returning to the outpatient clinic within three days.

VHA Comments

The Chief Network Officer concurred with the above recommendations and noted actions taken, initiated, and planned to respond to the concerns. Regarding recommendation 6.e., the Chief Network Officer noted the importance of clarifying the difference between the need for disciplinary action due to inappropriate care and the need to provide feedback when a treatment plan is appropriate, but not effective. The Chief Network Officer's complete comments are in Appendix B.

OIG Response

The Chief Network Officer's comments were responsive and we will follow up on the plans to resolve the recommendations. We should clarify that the OIG discussed many of its findings with the Quality of Care Task Group at the time of their visit to the CAVHCS on February 2-4, 1998. Prior to the group's visit, the OIG had conducted multiple health care inspections during five separate site visits, the findings of which resulted in the recommendations in our report. This Task Group confirmed many of the problems previously identified by the OIG, and made similar recommendations for corrective action.

Issue 2: Staffing Nursing Units

We partially substantiated an allegation concerning understaffed nursing units. Several additional allegations were unsubstantiated.

Allegation 1: Various nursing units at the East Campus are generally understaffed.

We partially substantiated this allegation. We asked a nursing management expert to review nursing staffing patterns, in relation to patient workloads in the East Campus Nursing Home Care Unit, Intermediate Care, and Acute Medicine wards. The nursing consultant reviewed the adequacy of nursing staffing, at randomly selected points during 1997, using the staffing methodology that East Campus nursing managers use to assign nursing employees. Our nursing consultant concluded that all of the Nursing Home Care Unit and Intermediate Care wards were moderately to severely understaffed on the days that she evaluated, even in consideration of their own staffing guidelines. The problem appeared to stem from an uneven distribution of the numbers and categories of employees, on a shift by shift basis.

Using VHA's nurse staffing methodology, the consultant found an understaffing of registered nurses and licensed practical nurses on Intermediate Care and Psychiatry wards. The Nursing Home Care Unit did not reflect the same shortage as other wards; however, the nurse consultant's study did show the Unit was slightly understaffed. The formulas used by the nurse consultant showed similar nursing assistant shortages. The nursing consultant did not find that similar understaffing conditions existed in acute care wards.

Our nursing consultant emphasized that the need for nursing staff in wards may actually be greater because East Campus staff were not excluding employees on duty who were not engaged in providing direct patient care. Second, the nursing consultant noted that East Campus staff did not have support systems available to them, that are available in most other medical centers, to save time that could otherwise be available to directly care for patients. For example, East Campus does not have:

- direct access to computerized laboratory results;
- electronic medication ordering capability;
- 24-hour or consistently available Respiratory Therapy coverage for patients who have oxygen concentrators, or who need nebulizer therapy; and
- patient transportation services to escort patients to therapy or clinic/consultation appointments.

Lacking these fundamental nursing support procedures and services, nursing employees have to fulfill the duties to ensure that patients receive the attention and treatment that they need.

Interviews with several nursing employees and a review of nurse managers' administrative records disclosed that employees do not like being temporarily transferred from one unit to another in response to changes in patient census or acuity of patient care. We concluded that it is standard practice, in virtually all hospital settings, to redistribute nursing employees in such a manner as to best accommodate patients' needs. At the time of our inspection, East Campus managers initiated redistribution of nursing staff from areas which were overstaffed to those which demonstrated continuing nursing staff deficiencies.

The CAVHCS Director needs to ensure that nursing managers use state-of-the-art nursing staffing methods in order to ensure that all wards are properly staffed to meet patient care needs. The Director should also seriously consider establishing the types of nursing and patient support services that we list above, in order to free nursing staff time to attend to direct care pursuits.

Unsubstantiated allegations

We did not substantiate the following allegations pertaining to nursing care at the East Campus:

- A complainant alleged that, in 1995, nursing managers withheld from JCAHO surveyors classification information on the complexity of nursing care provided to East Campus patients because, if the true classifications were disclosed, it would be apparent that there was insufficient nursing staff. Nurses routinely assign patients into categories that define the level and intensity of nursing care that they require. The categories range from I to IV, with category I patients requiring the least care and Category IV patients requiring the heaviest or most intense care. A complainant submitted a handwritten, undated, unsigned note which she alleged was a copy of an instruction given to nurses not to place any patient on category IV because "we don't have enough staff to do one to one." Nursing managers denied ever having instructed ward nursing employees to refrain from using classification IV. We did not find any registered nurses who said that nursing managers had instructed them to falsify patients' classification. On July 16, 1997, we made unannounced visits to three units and evaluated randomly selected patient classifications. We found that all of the patients were correctly categorized based on their nursing need, including the two who were found to be classified at level IV.

- A complainant alleged that nursing employees do not assist with personal care, especially in the Nursing Home Care Unit. The allegation was vague, and no specific patients currently in the East Campus were identified for us to evaluate. We made several unannounced visits to the Nursing Home Care Unit and found that patients were fairly clean and well groomed.

- A complainant alleged that a patient's medical condition deteriorated when he was transferred from the West Campus to the East Campus in April 1997. It is true that the patient developed pneumonia while he was an East Campus patient; however

clinicians treated the condition appropriately and it is unlikely that the pneumonia was a result of deficiencies in his care at the East Campus.

- A complainant alleged that nurses at the East Campus lacked supplies to provide appropriate nursing care. Some nurses, who were recently transferred to the Nursing Home Care Unit from psychiatry wards, told us they lacked, or had difficulty obtaining, supplies. Interviews with randomly selected nurses in various units throughout the facility revealed that although operating supplies occasionally deplete, the Nurse Officer of the Day provides them with adequate supplies when asked. The newly transferred nurses may not have learned as yet how to procure needed supplies, which may have led to the allegation.

Conclusion

We concluded that nursing managers had not consistently ensured adequate nursing employee staffing levels in several long-term care areas, raising the potential for unsafe patient care.

Recommendation 7

The Director, CAVHCS, should require nursing managers to use the data from the VA-prescribed Methodology for Nurse Staffing and Resource Management, and to consider a staffing methodology that is more responsive to changes in patient census and acuity. For example, certain employees might be specifically assigned as temporary "float" nurses to whichever unit requires the most assistance.

VHA Comments

The Chief Network Officer partially concurred with the recommendation, noting that the VA Methodology for Nurse Staffing and Resource Management does not reflect the flexibility required to manage an integrated healthcare system. The Chief Network Officer noted actions taken to respond to the recommendation. His complete comments are in Appendix B.

OIG Response

The Chief Network Officer's comments were responsive to our recommendation. We will follow up on the actions planned to resolve the recommendations.

Issue 3: Patients' Nutritional Care

We received allegations related to the provision of appropriate nutritional care for East Campus patients, including regular and special diets, enteral or tube feeding, and intravenous feedings. We found that clinicians did not always properly manage the administration of enteral (tube feeding) nutrition, patient weighing procedures could result in inaccurate information, sufficient numbers of nursing employees were not always available to feed patients, and some employees were eating patients' food.

Allegation 1: Clinicians did not properly manage an East Campus patient's tube feeding.

We substantiated this allegation. The patient, a 76-year-old man, was admitted to a medical ward on November 18, 1994, as a "social admission," because he was reportedly falling at home and his family was unable to find a suitable community placement. Two months after his hospital admission, clinicians transferred him to the Nursing Home Care Unit. In May 1996, the patient was receiving a tube feeding and a dietitian assessed the patient as moderately nutritionally compromised. Notwithstanding the fact that his nutrition was identified as a problem, his intake record was notable for a wide range in the amount of the feeding formula given to the patient. For example, for the period from July 16 to July 20, 1996, his recorded daily intake varied from 800cc – 2040cc, yet the patient's physician did not change his tube feeding order to account for this large variance. This suggests a lack of appreciation for, or understanding of, the significance of nutrition in patient care, or a lack of attention to the patient's needs.

We did not identify any similar incidents, nor were any other specific patients brought to our attention by the complainant. However, we identified some unsatisfactory treatment practices relating to tube feeding, which, in combination, could lead to similar incidents at the East Campus. These issues include: appropriateness of feeding tubes, monitoring of gastric retention and residuals, administration of free water, and recording of volumes and types of fluids infused**.**

Feeding Tubes: We found that most of the patients on naso-gastric tube feeding had fairly large, rigid feeding tubes. A variety of soft, fine-bore feeding tubes are currently available. One advantage of the smaller, softer tubes is their flexibility and small size, which increase patient comfort in long-term use.[16] Nursing employees told inspectors that the supply of smaller, soft feeding tubes was depleted and they were no longer being purchased. The Associate Chief Nurse for Medicine and Intensive Care Unit told us there were no flexible tubes available. However, we found these types of tubes were available through the Chief, Supply Processing and Distribution Section. The Chief, Supply Processing and Distribution said he was in the process of reorganizing the

[16] Evans-Stoner, Nancy and Lycen Lucinda K., Clinical Nutrition in The Nursing Clinics of North America, Volume 32, No. 4, December 1997, page 688.

patient care supply storage areas to improve the availability of all supplies. We believe the failure of Nursing Service to communicate with the Supply Processing and Distribution Section led to the widespread use of less comfortable tubes in this patient population.

Gastric Retention/Residuals: During tube feeding, it is important to monitor the amount of formula in patients' stomachs in order to assess their tolerance for the feedings, and decrease the risk of aspirating stomach contents into their lungs. The registered nurses whom we interviewed cited varying amounts of the volume of tube feeding residuals that would stimulate them to hold or decrease the amount of formula they administered. We reviewed physicians' tube feeding orders and found that generally, physicians did not order nurses to monitor for gastric retention, which reinforces the need for the nursing employees to monitor gastric retention themselves. The facility's nursing procedure for nasogastric tube feeding (Procedure No. 95-N-6) requires an infusion rate change, and describes needed actions when the amount of stomach residuals exceeds a certain volume. These standards were not consistent with standing doctors' orders for tube feeding patients. Inspectors could not reach any definitive conclusion with respect to whether inconsistent monitoring of gastric retention adversely impacted patients' conditions. Nonetheless, the risk of patient harm is increased if residuals are not monitored.

Hydration: Appropriate hydration is necessary in order to avoid metabolic complications, such as electrolyte abnormalities, constipation, and dehydration. Clinicians should estimate each patient's specific free water requirements, as each patient's physiological needs and prescribed tube feeding formula may vary. We found that clinicians did not always determine patients' requirements for free water. When water was ordered, most doctors' orders indicated the same standard volume of water regardless of the patients' conditions. We could not make any definitive judgments with respect to whether inconsistent determinations of free water requirements adversely impacted the patients' conditions. However, the standard of care requires adequate monitoring of free water administered.

Recording of Volume Infused: Nurses do not consistently record the volume of tube feeding formula and water that are infused on a daily basis. It was not clear from the medical records what amount of water and amount of formula the patients received. Therefore, clinicians could not possibly accurately determine patients' intake of nutrients and water.

Allegation 2: Clinicians did not properly manage total parenteral nutrition.

We could not substantiate or refute this allegation, because at the time of our visit there were no patients receiving parenteral nutrition at either campus. However, inspectors reviewed the locally developed procedures for managing patients who require parenteral nutrition. The East Campus has a Nutrition Support Team comprised of a physician, a registered clinical dietitian, a registered nurse and a pharmacist. The

Nutrition Support Team monitors the metabolic, mechanical and infectious complications of parenteral nutrition, and provides employee in-service education.

Although the Nutrition Support Team established standard doctor's orders for parenteral nutrition, and Nursing Service had a total parenteral nutrition procedure (No. 95-N-7), these instructions did not adequately address all sections required by VHA policy (Manual M-2, Part I, Chapter 33, "Specialized Nutritional Support"). Examples of sections that local instructions did not address include: indications and contraindications; complications and their preventions; method of terminating therapy; and living wills.

Allegation 3: Patient weighing procedures at the East Campus could result in inaccurate information.

We substantiated this allegation. The facility's established patient weighing procedures could result in inaccurate information. We examined one temporary record of patients' weights, and found that the method that nursing employees used to temporarily record patients' weights could result in erroneously transposing weights to patients' permanent medical records. Nursing employees did not always erase patients' names when they were transferred to another bed. Consequently the new patient's weight was recorded on the line bearing the previous occupant's name.

Nurses told us that scales that are specially manufactured for bed-bound and wheelchair patients were not always available. The employees told inspectors that due to the limited number of special scales, they had to move the scale from one unit to another. This practice could affect the calibration of the scales and result in erroneous patient weight measurements.

We reviewed weight data on a random sample of 61 patients. Nursing employees had recorded weight losses for 36 percent (22/61) of the sample. Twenty percent (12/61) of the patients lost 5 pounds or more (less than 5 pounds may not be significant because of physiological fluctuations in fluid balance) from March 1997 to July 1997. In June 1997, 22 of the 61 patients did not have a recorded weight on the weight chart. One patient had demonstrated consistent weight loss yet clinicians did not re-weigh him for one month.

The weights of patients in our sample ranged from 80 to 215 pounds. Twenty-three percent of the patients (14/61) weighed less than 120 pounds, including three who weighed less than 100 pounds. These findings demonstrate that consistent monitoring of weight in this patient population is critical due to weight fluctuations and some low weights.

A previous OHI report (Number: 6HI-A28-072, July 17, 1996) discussed seriously flawed weighing procedures in the East Campus' Nursing Home Care Unit. Managers responded to OHI's concerns in that case by developing policies and procedures for

employees to follow in performing this task. Apparently, managers did not implement, or employees did not comply with, the action plans the CAVHCS Director described.

Allegation 4: At the East Campus, there are not enough nursing employees to feed patients who require assistance.

We substantiated this allegation only to the extent that employees do not always adequately assist patients with feeding or other activities of daily living. We could not substantiate that this was entirely due to inadequate staff.

We observed several patients during evening meals. Many appeared to be in need of assistance to eat, in that they were physically infirmed and in some cases so demented that they could not request assistance. However, nursing employees did not appear to provide adequate feeding assistance to them. A nursing employee told us that patients eat their big meal each day at lunch. Several nurses asserted they did not believe there were enough nursing employees or volunteers to feed the patients. One nurse told us she knew of 26 patients who needed to be fed on her unit, but that she only had five nursing employees on duty to do the work. She emphasized that, on that particular day, there was no way the patients could be fed in a manner that would ensure that the food would be sufficiently hot or cold, appetizing, or adequate to their nutritional needs.

The medical center has adaptive equipment, such as lip plates, that nursing employees can use to facilitate the patients feeding themselves. Voluntary Service also coordinates a Meal Mates Program, which recruits community volunteers to feed patients, but this does not appear to be sufficient to provide feeding services to all patients in need of help.

Allegation 5: Some employees were eating patients' food.

We substantiated that employees have eaten food sent to the units for patients, but did not substantiate that any patient was deprived of food. Nurses testified that employees sometimes eat food sent to patients. The nurses also testified that they had seen employees consuming food and drinks intended for patients, but they could not cite specific times, places, or persons involved in these incidents.

Unsubstantiated allegations

We did not substantiate the following allegations concerning patients' nutritional care:

- A complainant alleged that East Campus dietitians spend only $1.26 to $1.46 a day to feed each patient. We reviewed the Nutrition and Food Service worksheets for Computing Dietetic Service Food Cost of Meals Served Report for each quarter of Fiscal Years 1994, 1995, 1996 and the first quarter of Fiscal Year 1997. During these 13 quarters, the average cost per meal was $1.61 or $4.83 per day for three meals. The expenditure for meals ranged from $1.40 per meal, or $4.20 per day, for three meals, to $1.95 per meal, or $5.85 per day, for three meals. This cost data

reflects only raw food costs and does not include operational expenses (e.g., labor, supplies, equipment, energy, etc.). During Fiscal Year 1996, the average cost per meal for the East Campus was $1.71 ($5.13/day) compared to $1.57 ($4.71/day) average cost for VHA nationally. Therefore, in our view, the food cost at the East Campus was adequate.

- A complainant alleged that prescribed diet supplements were not always available at the East Campus. The Nutrition and Food Service provides a wide spectrum of commercial supplements and food items for nutrition therapy to patients with a variety of medical problems such as renal failure, gastrointestinal disease, and diabetes mellitus. On July 15, 1997, we reviewed diet orders on 148 inpatients and found 48 patients (32%) for whom clinical employees had prescribed commercial nutritional supplements, tube feedings and food supplements. We observed nutritional supplements being delivered to many inpatients on their meal trays. We also examined the contents of a psychiatric unit refrigerator and found that it contained a variety of nutritional supplements and food items. During the inspection of food service storage areas, we found a variety of nutritional formulas in stock.

- A complainant alleged that a patient had a choking episode that resulted in his death. The 68-year-old patient had diagnoses that included dementia, diabetes mellitus, and arteriosclerotic heart disease. Clinicians admitted him to the East Campus medical ward on October 4, 1996, for long-term care. Clinicians considered the patient to be at risk for choking, and noted that he "would not swallow." His nutritional status was considered mildly compromised, and he was fed through a naso-gastric tube. Clinicians transferred the patient from the medical ward to a Nursing Home Care Unit ward on November 4. On November 13, his condition worsened, and clinicians transferred him to an acute medical ward. His condition further deteriorated, his pulse and respiration ceased, and clinicians could not revive him. There was no documentation that the patient had a choking episode prior to his condition deteriorating.

  We observed many patients who were receiving meals that were modified in consistency to make it easier for them to swallow. The East Campus had an informal group comprised of a speech pathologist, a radiologist and a dietitian, who evaluated patients and developed feeding strategies for those who had swallowing problems. We found this appropriate.

Conclusion

East Campus employees did not demonstrate appreciation for, or knowledge of, specialized patient nutrition requirements. Even though we did not identify any instances in which patients were harmed by the knowledge deficit, managers need to implement education and training opportunities to improve this important treatment area. One essential area, that of obtaining accurate patient weights, continues to be deficient. Clinical managers need to substantially strengthen procedures in order to provide physicians with accurate and timely patient weight data.

Recommendation 8

The Director, CAVHCS, should:

a. Require clinicians to evaluate procedures for appropriate delivery of enteral nutrition, including use of proper tubes, monitoring of residuals, administration of free water, and documentation of amount of formula and water administered.

b. Require the Nutrition Support Team to develop a parenteral nutrition protocol that is consistent with VHA's Chapter on "Specialized Nutritional Support" and current relevant nutritional and medical literature.

c. Form an interdisciplinary team to arrange for the provision of staff training regarding the provision of specialized nutrition support.

d. Require nursing managers to establish, implement, and monitor compliance with a consistent procedure for obtaining, recording and monitoring patient weights throughout the facility.

e. Require nursing managers to provide adequate quantities and types of scales.

f. Require nursing managers to ensure that knowledgeable employees are available to assist patients who require help with feeding.

VHA Comments

The Chief Network Officer concurred with recommendations 8.a. through 8.e., and partially concurred with recommendation 8.f. He noted actions taken and planned to respond to the recommendations. Regarding recommendation 8.f., the Chief Network Officer noted that the OIG report did not cite any cases where veterans had not been fed. His complete comments are in Appendix B.

OIG Response

The Chief Network Officer's comments were responsive to, or met the intent of, our recommendations. We consider recommendations 8.b., 8.c., and 8.e. resolved, and will follow up on the remaining recommendations to ensure the planned actions are taken. Regarding recommendation 8.f., while our report did not cite specific patients who were not fed, our observations and interviews with nurse employees showed there was not adequate feeding assistance provided to all patients that require this aid at every meal to ensure sufficient nutrient intake. We will continue to follow up on VHA's plans to resolve this issue.

Issue 4: Patient Abuse

We substantiated an allegation that an East Campus patient was physically abused, and no one was disciplined. We received other allegations of patient abuse at both the East and West Campuses, which we did not substantiate.

Allegation 1: A patient was physically abused at the East Campus, and no one was disciplined.

We substantiated this allegation. On the August 18, 1995 evening tour of duty, a registered nurse found an East Campus Nursing Home Care Unit patient in his wheelchair. The wheelchair was tied to a side rail in the dayroom. His body was restrained, and he was soiled with feces and urine. The nurse also noted that the right side of the patient's face and his right eye had an estimated 2 to 3 day-old laceration and bruise. The nurse wrote a memorandum to the nurse manager, but did not record her findings in the patient's medical record.

The CAVHCS Director convened an Administrative Board of Investigation on August 23, 1995. The board sustained the allegation that physical abuse occurred. Board members could not, with certainty, identify the abuser(s), but they strongly suspected that two particular nursing employees were responsible, because they had been assigned to the patient on August 16, and these two employees were the first ones to notice the bruises, but did not report them.

The CAVHCS Director wrote a memorandum to the Regional Director regarding this case, stating his intent to discipline a nursing assistant, two registered nurses, a licensed practical nurse, and a medical doctor because:

- The two employees did not report the bruises that they noted.
- A Nurse Supervisor and Manager did not fulfill their supervisory roles.
- A physician told the nurse not to report the abuse.

As of November 13, 1997, only one nursing assistant had received a disciplinary action. The other employees were not disciplined as planned. According to a human resources specialist, Nursing Service managers did not want to discipline the registered nurses if the physician was not also disciplined. The Chief of Staff did not discipline the physician. We did not find any evidence that the Director followed up on these disciplinary issues. Therefore, the facility failed to act appropriately on a confirmed allegation of patient abuse.

Unsubstantiated allegations

We did not substantiate the following allegations regarding patient abuse at the East and West Campuses:

- A complainant alleged that patient abuse at the East Campus was not investigated. The East Campus had six reported patient abuse incidents during Fiscal Year 1996, all of which were appropriately investigated. The complainant did not identify any specific cases that were not investigated. Our review found that administrative investigations were generally appropriate and timely. However, it appeared that clinical managers did not always consistently pursue administrative actions against physicians and registered nurses who were involved in patient abuse incidents. The CAVHCS Director did not justify his reasons for not implementing recommended actions in at least two cases.

- A complainant alleged that an East Campus nursing assistant treated a patient rudely. On September 16, 1997, the complainant alleged that the patient was in his wheelchair, trying to leave his room. At the same time, the nursing assistant was in the process of lifting another patient to a wheelchair using a mechanical lift when the nursing assistant allegedly spoke harshly to the patient, stating "…back up … back up like I tell you."

  The patient's medical record shows that a registered nurse who witnessed the incident wrote a late-entry progress note dated October 4, stating the "Vet was spoken to inappropriately by staff member and vet got upset. Vet tried to communicate to staff that he did not appreciate being spoken to in the manor [sic] which had occurred. Staff member proceeded to speak angrily back to vet and this escalated the vet's anger. Writer attempted to intercede without success… Vet escalated at this point to the point of profanity and angry verbal interaction with other patient." Another nurse was able to pacify the patients and the nursing assistant.

  On October 5, the nursing assistant wrote a progress note denying that he spoke to the complainant inappropriately. He wrote that he only asked the complainant to move his wheelchair back so he could move another patient.

  We noted some delay in completing the administrative investigation of this incident. The nurse who witnessed the incident reported it on October 9, the same day that the patient complained to the OIG inspectors. The administrative investigation started on October 17, 1997, and was completed on February 19, 1998. The administrative investigation confirmed the exchange of profane words between the two patients. The patient in the wheelchair became upset when a registered nurse spoke to him about his use of profanities because the other patient was not spoken to about his use of profanities. The investigation determined that the patient's reaction was typical of his past behavior.

- A complainant described a case of alleged patient abuse at the West Campus, which managers did not investigate. The patient's medical records show that there was no episode of care documented since 1986. The same complainant gave the names of four employees who may have abused patients. We interviewed supervisors and other employees who had worked with the accused employees, and none had knowledge about, or had witnessed incidents of, patient abuse.

Conclusion

Medical Center Managers authorize and conduct formal administrative investigations on patient abuse issues when they occur. Nevertheless, as previously discussed under Issue 1, the Director appears to be reluctant to deal appropriately with physicians when administrative actions are indicated. This disparate treatment is potentially destructive of employee morale and gives tacit permission for physicians to behave improperly.

Recommendation 9

The Director, CAVHCS, should take appropriate disciplinary action against employees found to be abusive toward patients.

VHA Comments

The Chief Network Officer concurred with the recommendation, and noted corrective action planned. His complete comments are in Appendix B.

OIG Response

The Chief Network Officer's comments were responsive to our recommendation. We will follow up to ensure the planned action is implemented.

Issue 5: Physical Medicine Rehabilitation

We reviewed several allegations regarding the competency of Physical Medicine and Rehabilitation (PM&R) Service practitioners at the East Campus, and the appropriateness of patient care provided by that Service. We did not find any serious problems.

Allegation 1: An East Campus physiatrist made errors in interpreting three patients' electromyograms.

We partially substantiated this allegation. The physiatrist in question interpreted three patients' electromyograms to evaluate carpal tunnel syndrome. We asked a board-certified physiatrist to assess the accuracy of the physiatrist's interpretations. The consulting physiatrist agreed with the subject physiatrist's interpretation that one patient had bilateral carpal tunnel syndrome, but concluded that the electromyogram provided insufficient evidence to determine if the patient had peripheral neuropathy, which the subject physiatrist had diagnosed. The consultant physiatrist also pointed out that the electromyographer had not done a left-sided study; therefore, the subject physiatrist's comparison between the patient's right and left side conduction patterns was erroneous. We did not identify any harm to the patient. Our consulting physiatrist agreed with the subject physiatrist's interpretation of the other two patient's electromyogram.

Allegation 2: The former Chief, PM&R Service alleged that the Acting Chief, PM&R, a non-board-certified physiatrist, inappropriately changed her ultrasound treatment prescription for a patient, which increased the patient's pain.

We partially substantiated this allegation. OHI's consultant physiatrist stated that the use of ultrasound in the presence of a carpal tunnel syndrome, as severe as that shown by the electromyogram, was questionable. At best, the ultrasound was a therapeutic trial. Either of the prescribed ultrasound therapies could have positive and negative effects. The most important instruction would be to discontinue the treatment if symptoms worsened [which the subject physiatrist did]. OHI's physiatrist consultant did not believe that either prescription represented a grievous failure in the standards of care.

OHI's physician does not believe that one physician should change another physician's prescription except in emergency situations. The Acting Chief, PM&R Service told us that he increased the ultrasound dose because the patient had a thick palm. Notwithstanding the reasonableness of the explanation, the Acting Chief should have discussed the rationale for changing the treatment order with the other physician.

Unsubstantiated allegations

We did not substantiate the following allegations pertaining to physical medicine and rehabilitation:

- A complainant alleged that East Campus managers improperly permitted a physician assistant (PA) to function as the Acting Chief, PM&R Service during the Acting Chief's absence. The PM&R Service has one physiatrist (the Acting Service Chief), and one PA to care for the patients' medical needs. In the absence of the Acting Chief, a cardiologist served as the PA's supervisor and consultant. Although the cardiologist is not physically present in the outpatient or inpatient rehabilitation areas, the PA consults with the cardiologist when he has questions. The cardiologist co-signs all consultations and progress notes that the PA writes. The PM&R Service coordinator, a physical therapist, told us that there was no official document designating the cardiologist as the PA's supervisor; however, the cardiologist has substituted for the Acting Chief in the past. We were told that the PA keeps in close telephone contact with the cardiologist. We did not identify any incident in which a patient was harmed as a result of this supervisory relationship.

- A complainant alleged that a physiatrist (the Acting Chief of PM&R Service) inappropriately refused to prescribe whirlpool treatment for a patient's pressure sores. The complainant alleged that a patient had a pressure sore on his groin that was attributable to lower extremity contractures. The complainant alleged that the Acting Chief, PM&R Service refused to prescribe whirlpool treatments for the patient because the patient was "difficult" to handle. The attending physician told us that the patient received whirlpool treatments from September to December 1996. In December, the physiatrist determined that the patient had received maximum benefits from whirlpool treatment. The attending physician agreed with the physiatrist's evaluation, and the physicians mutually agreed to discontinue the treatment. The attending physician stated that the patient's pressure sores were healing well at the time of our interview.

- A complainant alleged that a patient developed septicemia from receiving treatments in a dirty Hubbard™ tank. From August 19 to October 8, 1996, the patient received daily whirlpool baths. At our request, an East Campus infection control practitioner reviewed this case and determined that the patient's septicemia probably stemmed from a urinary tract infection and not from the whirlpool, because the infection occurred about 8 weeks after the patient had his last whirlpool treatment. We also reviewed the medical center's compliance with requirements for cleaning the various equipment used in the PM&R Service. We concluded that PM&R Service infection control practices are effective and in force.

Conclusion

We did not identify serious problems associated with the PM&R Service. There were differences in professional opinions which could have been resolved if practitioners communicated effectively, but the differences did not result in patient harm. While we did not identify any patient care-related problems stemming from the supervisory relationships between the PA and the substitute Acting Chief of PM&R Service, the supervisory authority should be formalized and the supervisor should have regular contact with the PA during his day-to-day activities.

Recommendation 10

The Director, CAVHCS, should:

a. Review the appropriateness of the current physician supervisory relationship with the physician assistant in the absence of the Acting Chief, PM&R Service.

b. Require the relief-physician to make rounds regularly, and as needed with the physician assistant, to personally evaluate any patient whose treatment requires his/her co-signature.

c. Ensure the Acting Chief, PM&R Service discusses treatment changes with prescribing physicians before he revises prescriptions.

VHA Comments

The Chief Network Officer concurred with the above recommendations and stated that actions have been taken to resolve the concerns. His complete comments are in Appendix B.

OIG Response

The actions taken were responsive to our recommendation and we consider the issues resolved.

Issue 6: Respiratory Therapy and Supply of Liquid Medication Services

We substantiated allegations that the East Campus has insufficient staff to provide the full range of needed respiratory therapy services, and that appropriate liquid medications were not provided for Nursing Home Care Unit patients.

Allegation 1: Respiratory Therapy services at the East Campus were not available due to inadequate resources.

We substantiated this allegation. Because the complainant did not provide a specific date on which services were not available, we were unable to review specific incidents. We did, however, review the Respiratory Therapy Section's staffing and hours of operation. We also interviewed the section supervisor and reviewed the section's staff meeting minutes. We concluded that the East Campus has insufficient staff to provide the full range of needed respiratory therapy services.

The Respiratory Therapy Section has undergone changes since April 1996. The section was renamed the Cardiopulmonary Section, and a new supervisor was appointed. The supervisor informed us that the current staffing complement is inadequate to accomplish the Section's functions. However, we did not find any evidence that the Cardiopulmonary Section Chief, or her supervisor had asked for additional employees other than replacements for departing employees. The Electrocardiogram Clinic, a major Cardiopulmonary Section responsibility, performs 20 to 28 tests daily, 5 days a week. Cardiopulmonary Section employees also perform an average of two pulmonary function tests daily for compensation and pension examinations. Respiratory therapists perform respiratory treatments only on the acute care units and the Intensive Care Unit.

Respiratory therapists are present in the medical center from 8:00 a.m. until midnight, Mondays through Fridays. On the weekends, the coverage is from 11 a.m. to 8 p.m. Therapists take their turn taking paid 'call.' Since some therapists live far (30 miles) from the East Campus, on call responsibilities represent a hardship for many of them. Therapists told us that they are occasionally recalled shortly after they arrive home after responding to a 'call.' In addition they asserted that sleep disruption hinders their ability to perform at an optimum level on the following workday. Moreover, since the facility offers critical care services, including continuous mechanical ventilation, it should have respiratory therapy capability in-house 24 hours a day, 7 days a week.

Only therapists are allowed to do electrocardiograms except in the Intensive Care Unit. The absence of therapists delays electrocardiograms for patients who come to the emergency room with possible heart attacks. We were told that emergency room employees were not allowed to do the procedure because of concerns that they might damage the equipment. We believe that the practice of waiting for an 'on call' electrocardiogram technician possibly places seriously ill patients at risk for delayed diagnosis and treatment. Other employees can, and should, be trained to perform this function.

Allegation 2: The East Campus Pharmacy Service does not provide appropriate liquid medications to the Nursing Home Care Unit.

We substantiated that Pharmacy Service does not routinely provide appropriate liquid medications for Nursing Home Care Unit patients, but did not substantiate that this was the fault of the Pharmacy Service. In July 1997, in the course of reviewing issues pertaining to the administration of tube feeding, nurses told inspectors that one of the reasons that they use large-bore feeding tubes is that small bore tubes become clogged with medications that they must liquefy. Nurses complained that they spend an inordinate amount of time crushing tablets into powder, and mixing them into a solution before they can administer some medications through a tube. They complained that Pharmacy Service did not provide them with liquid medications. The Nursing Home Care Unit pharmacist acknowledged that he does not compound tablets into liquid form. The Chief of Pharmacy, however, asserted that the pharmacy would provide liquid medications if nurses or physicians specifically ask for them. Nursing Home Care Unit nurses had not requested such medications. We conveyed this information to the Long-Term Care Nursing Director. In September 1997, the Long-Term Care Nursing Director told inspectors that a committee had been formed to explore the issue of liquid medication availability. The committee had not, at the time, resolved the issue; and liquid medications were still not routinely available for tube administration.

Conclusion

Since the Cardiopulmonary Section provides critical care services, including urgent ECGs and continuous ventilator support, the Section either needs adequate numbers of employees to provide 24-hour coverage, 7 days a week, or the Section Chief needs to provide sufficient training to selected nursing employees to ensure that these critical care functions are adequately accommodated in the therapists' absence. The Director needs to immediately resolve the liquid medication issue, if clinicians cannot quickly resolve the matter.

Recommendation 11

The Director, CAVHCS, should:

a. Authorize and recruit for additional respiratory therapy employees to accomplish the Cardiopulmonary Section's mission, and establish a cross-training program whereby other properly skilled clinical employees can learn the fundamentals of the section's duties such as electrocardiograms.

b. Facilitate the routine availability of liquid medications on the Nursing Home Care Unit.

VHA Comments

The Chief Network Officer concurred with the recommendations and noted actions taken to resolve the concerns. His complete comments are in Appendix B.

OIG Response

The Chief Network Officer's comments were responsive to recommendations 11.a. and 11.b. and we will follow up on the plans to resolve the issues. We should clarify that the OIG discussed many of its findings with the Quality of Care Task Group at the time of their visit to the CAVHCS on February 2-4, 1998. Prior to the group's visit, the OIG had conducted multiple health care inspections during five separate site visits, the findings of which resulted in the recommendations in our report. ***(b)(3)***

Issue 7: Medical Officer of the Day

We substantiated that a physician worked continuously for up to 4 days. We did not substantiate another allegation regarding a Medical Physician on Call.

Allegation 1: A physician worked continuously for up to 4 days as a Medical Officer of the Day.

We substantiated an allegation that a physician worked continuously for up to 4 days when other MODs only worked for 24 hours at a time. The complainant did not allege that any patient had been harmed by this physician as a result of his working such long hours.

OHI inspectors reviewed a MOD roster for May 1997. The roster showed that the physician in question worked continuously from 6:00 p.m. on Friday, May 23, through 7:00 a.m. on Tuesday, May 27 (85 hours). Another roster for July 1997 showed that this physician worked from 7:00 a.m. on Friday, July 4, through 7:00 a.m. on Monday, July 7 (72 hours). We did not receive any reports that patients were harmed as a result of this practice, but we nevertheless agree with the complainant that there is a fatigue factor that raises the potential for harm to patients.

Unsubstantiated allegations

We did not substantiate the following allegation regarding a Physician on Call at the West Campus:

- A complainant who served as MOD on March 22, 1997, alleged that he did not receive assistance and advice from the Medical Physician on Call relating to the appropriateness of a patient's blood transfusion. The complainant alleged that he admitted a patient who had been discharged 5 days previously. The complainant alleged that an attending physician was working as Medical Physician on Call that day, and that she knew the patient's background well. The complainant alleged that he asked the Medical Physician on Call for advice regarding the patient's care, but the Medical Physician on Call was not responsive.

  The Medical Physician on Call recalled that she tried to help the MOD, but that he abruptly terminated the phone conversation. A witness confirmed that he overheard the MOD using an unnecessarily loud voice during the conversation. The patient's medical records show that the Medical Physician on Call followed the patient even if she did not make this clear to the complainant, and that the patient ultimately received appropriate care.

  We interviewed eight clinical employees who routinely work in the outpatient area, and a physician who is responsible for coordinating MOD services. The employees whom we interviewed were familiar with the incident and had witnessed similar incidents between these two physicians. They felt that both physicians were clinically

astute, but there was a conflict in personal relations, and a struggle for professional position, rather than inadequate work performance. The problem was resolved when the MOD's contract was not renewed.

Conclusion

We did not identify any patient care problems that were associated with the MOD's long tour of duty. Nevertheless, OHI believes that there is a fatigue factor in such extended tours that raise potential dangers for patient harm to occur. Medical Center managers should be very circumspect in allowing any practitioner to be in an on-duty status for more than 24 hours at a time.

Recommendation 12

The Director, CAVHCS, should limit the number of hours physicians are scheduled to work continuously.

VHA Comments

The Chief Network Officer concurred with the recommendation and noted corrective action taken. His complete comments are in Appendix B.

OIG Response

The action taken was responsive to the recommendation and we consider the issue resolved.

Issue 8: Medication Errors, Responding to Emergencies, and Patient Safety

We substantiated that West Campus managers did not adequately investigate medication errors, East Campus cardiac monitor alarms in the Intensive Care Unit and Emergency Room were set too low, an East Campus code team was unable to enter a building to respond to an emergency, and the process by which clinicians evaluated "code green" effectiveness was not followed. We did not substantiate one allegation concerning patient safety at the East Campus.

Allegation 1: Managers do not adequately investigate medication errors.

We partially substantiated this allegation on the West Campus only. We reviewed East Campus medication error reports from Fiscal Year 1993 through Fiscal Year 1996, and concluded that clinical managers seem to have properly managed the reports of medication errors. They investigated predisposing factors, and provided appropriate training and employee counseling when indicated. Although it appears that the number of medication errors reported was low, considering the thousands of doses given each year, we did not identify any unreported errors that should have been reported.

Number of Reported Medication Errors at the East Campus

FY 1993	FY 1994	FY 1995	FY 1996
28	34	29	31

At the West Campus, Nursing Service and Pharmacy Service report medication errors separately to the Pharmacy and Therapeutic Committee each quarter. Pharmacy Service reported 70 medication errors for the four quarters in Fiscal Year 1996. At least 27 (38.5%) of the 70 Pharmacy medication errors consisted of mailing and filling errors (prescriptions mailed to the wrong patient, and wrong dosages). The Chief, Pharmacy Service told us that he was aware that these errors occur, and that he initiated an error prevention monitoring program in an effort to decrease medication errors. Pharmacy managers felt that the increase in reported pharmacy medication errors was a function of closer monitoring, and conscientious self-reporting by the staff.

One medication error involved confusion of insulin dosages. A patient had eight different orders for insulin, based on blood sugar monitoring results. Physicians had revised one or more of these eight orders nine times within a 24-hour period. Consequently, a nurse administered an insulin dose when it was not indicated. West Campus managers did not appreciate the confusion and inherent patient risk that these types of orders could cause. No one reviewed the error. Managers who reviewed the report determined that no action was required beyond reporting the error. In fact, the report was incomplete. A physician did not evaluate the error's effect on the patient, as is required by VHA policy.

Allegation 2: East Campus cardiac monitor alarms in the Intensive Care Unit and emergency rooms were turned off.

We substantiated this allegation. We made an unannounced visit to the Intensive Care Unit and found that, although nursing employees had properly connected the patients to monitors, the alarm volumes were set so low that alarms were inaudible at the nurse's station when the patients' heart rates exceeded established parameters. This practice defeated the purpose of the cardiac monitor alarms. The only way that nurses could know that a patient's heart rate went above or below accepted thresholds was by continuously observing the monitor. In one patient, the parameters for high/low heart rate tolerances that activated the danger alarm were set too high. The nurse explained that this high rate setting was chosen because the patient had such an irregular heart rate. We concluded that nurses appeared not to understand that the patients' heart rate instability was precisely one of the reasons why monitors are used, to alert nurses of labile heart rates.

We also found the same practice of "silenced" alarms in the Emergency Room where a patient was attached to a heart monitor. This practice is especially dangerous in the Emergency Room, because nurses are not always able to be in the room with the patient as is customarily possible in the Intensive Care Unit, and because emergency rooms are often quite noisy.

Allegation 3: East Campus code team members were unable to enter a building to promptly respond to an emergency, because the automatic door did not open.

We substantiated this allegation, but found that the problem had been addressed. The building in which this incident occurred is new, and had only been in service for about a month at the time of the incident. The main entrance door automatically locks when any patient who is wearing a "wandering bracelet" approaches the door. This automatic lock prevents confused patients from leaving the ward. During one emergency, when resuscitation team members needed to enter the building, a patient, wearing a "wandering bracelet", was standing near the door. The patient's proximity to the automatic locking device prevented the door from opening. The door can be manually opened, but directions on how to manually open the door were inside the building, and were not visible to the code team members from the outside.

East Campus managers subsequently remedied the situation by sending an e-mail message to all employees with instructions on how to open the door manually. We advised managers to also place operating instructions on the outside of the doors. On November 4, 1997, the Director of Nurses for Extended Care told us that signs have been placed on the outside door, and the ward attending physician verified this information. The patient who needed the emergency services died, but his death did not result from the delay, since unit clinical employees were available and properly initiated the code.

Allegation 4: "Code Greens" were ineffective.

We did not substantiate this allegation, but we did find that the process by which the clinicians are supposed to evaluate "Code Green" effectiveness was not followed. "Code Green" refers to a crisis response team which is available to intervene during actual or potentially violent episodes. We reviewed 51 "Code Green" critique forms that evaluated such episodes during the 4-year period November 14, 1992 to November 10, 1996, in order to assess the effectiveness of the crisis response team. The form includes 19 items that indicate the effectiveness of the team. Team members are supposed to indicate whether a criterion was or was not met.

We reviewed completed "code green" critique forms, and made the following observations concerning the team's effectiveness:

- No person or committee was responsible for evaluating "code green" activities.
- Code critiques were not consistently done.
- Some criteria were unclear. For example, if the item: Medication Administered was checked "No," does this mean a medication was ordered but not given or does it mean that none was ordered?
- Frequent mention was made about unspecified problems with beepers that prevented members of the team from responding to the crisis site, but there was no mention of problem resolution.
- The code team leader was not identified.
- Although some members of the team did not respond to the scene when called, no discussion of actions taken to address this issue was documented.

Unsubstantiated allegation

We did not substantiate the following allegation concerning patient safety:

- A complainant alleged that East Campus nurses administered dopamine to a patient even though it was not ordered. The patient's medical record does not show any indication that he received dopamine or any similar medication. The complainant did not provide information on the time or circumstance associated with this alleged incident. Thus a complete evaluation was not possible.

Conclusion

Medication errors can only be identified through self-reporting, or by someone who has direct knowledge that an error occurred. In general, most employees do not have an incentive to self-report, and thus many errors go unreported nationwide. We believe that this is the case at the East Campus; however, we could not demonstrate this in medical record reviews. Medical center managers need to emphasize the imperative to properly set physiological parameters on critical care monitors and to keep alarm volumes set at an audible level to ensure patient safety. The Director should require

the Chief of Staff to monitor the propriety and effectiveness of "Code Green" responses, and initiate actions where they may be indicated.

Recommendation 13

The Director, CAVHCS, should:

a. Assign "code green" evaluation activities to a quality management committee for quarterly assessments.

b. Require responsible employees to properly complete "code green" forms in a timely manner.

c. Instruct nurses to set cardiac monitor alarm volumes at the nurse's station high enough to be heard.

d. Instruct Intensive Care Unit nurses to set heart rate monitor parameters to an acceptable level for each patient.

e. Explore reasons for possible underreporting of medication errors, and remove disincentives for reporting, where it is possible to do so.

f. Instruct West Campus quality management employees to review all medication errors quarterly, and include physicians in the review process.

VHA Comments

The Chief Network Officer concurred with the above recommendations and noted that corrective actions have been initiated. His complete comments are in Appendix B.

OIG Response

The Chief Network Officer's comments were responsive to our recommendations. We will follow up to ensure that the planned corrective actions have been implemented. We should clarify that the OIG discussed many of its findings with the Quality of Care Task Group at the time of their visit to the CAVHCS on February 2-4, 1998. Prior to the group's visit, the OIG had conducted multiple health care inspections during five separate site visits, the findings of which resulted in the recommendations in our report. ***(b)(3)***

Issue 9: Care of the Patients' Environment

We substantiated some deficiencies in the cleanliness of the East Campus. We did not substantiate another allegation pertaining to the care of the East Campus isolation procedures.

Allegation 1: Some East Campus wards smelled of urine; the buildings were not clean; and employees slept while on duty.

We partially substantiated these allegations. Some of the bathrooms did smell of urine, but the wards appeared to be clean but cluttered. We did not find any employee sleeping while on duty.

Patient Care Areas: We made several unannounced inspections of various nursing units in July and August 1997. The nursing units, except the Intensive Care Unit and the newly opened units in Building 129, had a dominant scent of air freshener. Even so, some of the bathrooms had a smell resembling stale urine, even though employees told us that more housekeeping cleaning persons had been recently assigned to the nursing units. During our inspection of the newly opened nursing home building, we observed three cleaning employees on each unit. Nevertheless, the units were cluttered to the point of posing a safety problem.

We conducted an unannounced visit to the East Campus at 3:00 a.m. We visited eight wards in four separate buildings and did not find any employees sleeping. The buildings and wards were clean.

Main Kitchen: We assessed the East Campus' main kitchen area and observed the following: (i) the kitchen was neat in appearance; (ii) only one of six air current machines in the loading dock area was operating, and (iii) the outdoor garbage bins were open. Nutrition and Food Service managers told us that the food service and kitchen areas are sprayed for pest control weekly, although we did note a few insects in the kitchen during our tour. Subsequent to our visit, Nutrition and Food Service managers initiated a logbook to verify that pest control treatments have been completed in the building on a weekly basis. Managers told us they had ordered new blowers for the air current machines.

Unsubstantiated allegation

We did not substantiate the following allegation concerning patients' environment:

- A complainant alleged that patients with infectious diseases were not appropriately isolated from other Intensive Care Unit patients. The complainant alleged that Intensive Care Unit patients who required isolation because they had communicable diseases were separated from other patients only with a paper curtain. We made several unannounced visits to the Intensive Care Unit and found it was clean and orderly. Since there were no patients who required isolation at the times of our

visits, we could not directly evaluate infection control practices. The Intensive Care Unit has a separate room for isolating patients who have infectious diseases. However, employees told us that the negative airflow mechanism was not working properly. They stated that if more than one patient needed isolation, a room in the adjacent, closed unit would be used. During a later visit, managers told us that the Intensive Care Unit was to be closed and all patients requiring such care would be transferred to the West Campus. As of January 1998, the Unit was still open. Until the transfer occurs, the negative air flow mechanism needs to be made functional.

Conclusion

One essential factor in health facility management is to maintain a clean environment. We believe this imperative was not being consistently met, and managers needed to place increased emphasis on maintaining a clean, uncluttered patient care environment. Nutrition and food service managers should be vigilant in identifying any problem that contributes to pest infestation and vigorously pursue resolution of the problem.

Recommendation 14

The Director, CAVHCS, should:

a. Require an interdisciplinary team to conduct facility wide environmental evaluations of cleanliness, pest control, and safety hazards on a recurring basis.

b. Give high priority to work orders for correction of environmental problems at the East Campus.

VHA Comments

The Chief Network Officer concurred with the recommendations and noted corrective actions planned. Regarding recommendation 14.b., the Chief Network Officer stated that CAVHCS will give high priority to environmental problems at both campuses, not just the East Campus. His complete comments are in Appendix B.

OIG Response

The Chief Network Officer's comments were responsive and we will follow up on the plans to resolve the recommendations. We should clarify that the OIG discussed many of its findings with the Quality of Care Task Group at the time of their visit to the CAVHCS on February 2-4, 1998. Prior to the group's visit, the OIG had conducted multiple health care inspections during five separate site visits, the findings of which resulted in the recommendations in our report. ***(b)(3)***

Issue 10: Clinical Policies and Procedures

We substantiated two allegations that East Campus employees did not comply with standard procedures and policies, resulting in inefficient resource utilization, or potential patient harm.

Allegation 1: Clinicians inappropriately treated a patient in the Intensive Care Unit for about 5 years because he was a friend of the Chief of Staff.

We confirmed that the patient was in the Intensive Care Unit for nearly 5 years, but did not substantiate that this was because of a special relationship with the Chief of Staff. The patient was a 41-year-old male who had 24 diagnoses including psychiatric, neurological, and infectious conditions. Clinicians treated him in the Intensive Care Unit for about 5 years because he was chronically ventilator "dependent" and the Intensive Care Unit was the only unit that had the equipment and properly skilled staff to care for ventilator dependent patients. One social worker told inspectors that she, and other social workers, tried to transfer the patient to a more suitable location. However, they had not been able to locate a facility that would take ventilator dependent patients. A physician and social worker denied having any knowledge that the patient had a special relationship with the Chief of Staff; and we could not identify such a relationship.

Allegation 2: East Campus nursing employees do not follow Do Not Resuscitate procedures

We partially substantiated this allegation. We did not find any incident in which employees improperly resuscitated "Do Not Resuscitate" patients. However, several nursing employees were unclear on Do Not Resuscitate practices and policies.

Three of five registered nurses who had previously worked on psychiatric wards, whom we interviewed, said that they would resuscitate any patient whom they found without pulse or respiration, even though they knew that the patient had a Do Not Resuscitate order. The East Campus uses yellow bands to identify patients on Do Not Resuscitate status. Inspectors found that not all nursing employees understood the practice of placing yellow wristbands on patients to designate such status. This was particularly true for nursing employees who work in psychiatry. Furthermore, nursing employees told us that these yellow wristbands fade, and that the fading makes them an ineffective method of identifying Do Not Resuscitate patients. Medical record labels that indicate Do Not Resuscitate status were not applied consistently on various units. The East Campus policy does not specify how such patients' medical records should be labeled.

Even though the East Campus' Do Not Resuscitate policies are unclear and confusing, five randomly selected medical records of patients who had such orders when they died showed that clinical employees did not attempt to inappropriately resuscitate these patients. A test sample of five medical records of patients who did not have Do Not

Resuscitate orders when they died showed that employees attempted to resuscitate the patients.

Conclusion

Maintaining a patient in an Intensive Care environment for 5 years because of inadequate treatment skills in other venues is a poor use of resources. This could have been managed if the medical center had 24-hour in-house Respiratory Therapy capability. The meaning of the "Do Not Resuscitate" designation is a source of confusion nationwide and could be corrected by developing clear policies and procedures pertaining to the issue. We suspect that former psychiatry nurses had less knowledge of the issue, since do not resuscitate is not a common concern in the psychiatric population. Nevertheless, nursing managers should provide all nurses with orientation and training in this area.

Recommendation 15

The Director, CAVHCS, should:

a. Strengthen local Do Not Resuscitate policy by stipulating a standard method of labeling such patients' medical records.

b. Review and clarify policies and procedures related to Do Not Resuscitate orders and Advance Directives.

c. Provide training to employees in Do Not Resuscitate and Advance Directives procedures, and monitor their appropriate application.

VHA Comments

The Chief Network Officer concurred with the recommendations and stated that corrective action has been initiated. His complete comments are in Appendix B.

OIG Response

The Chief Network Officer's comments were responsive and we will follow up on the plans to resolve the recommendations. We should clarify that the OIG discussed many of its findings with the Quality of Care Task Group at the time of their visit to the CAVHCS on February 2-4, 1998. Prior to the group's visit, the OIG had conducted multiple health care inspections during five separate site visits, the findings of which resulted in the recommendations in our report. ***(b)(3)***

Issue 11: Clinical Management of Diabetes Mellitus Patients

We did not substantiate the following allegations concerning treatment of diabetes mellitus patients:

- A complainant alleged that an East Campus patient received inadequate care for his foot ulcer during a clinic visit, which subsequently resulted in the patient's foot being amputated. An East Campus outpatient clinic Nurse Practitioner saw this patient on June 20, 1997, when the patient came to the clinic to obtain an antibiotic that his private physician had prescribed. The patient presented himself at the clinic shortly after he had seen his private physician, and he had a fresh, clean bandage on his left foot ulcer. The patient reportedly told the Nurse Practitioner that his physician had told him the ulcer was resolving; therefore, the Nurse Practitioner elected not to personally examine the patient's foot. The Nurse Practitioner wrote a prescription for the antibiotic, and wrote in the patient's medical record that the patient's foot ulcer was resolving. We concluded that the Nurse Practitioner did not accurately record his findings, because he did not directly examine the foot ulcer. The patient was again seen during a July 23, 1997, Podiatry Clinic appointment, at which time his foot ulcer apparently appeared to be healing. Clinicians admitted the patient to the East Campus on July 30, with a diagnosis of gangrenous left foot. He was subsequently transferred to the VA Medical Center in Birmingham, where surgeons amputated his left foot. OHI's physician found no relationship between the need to amputate the patient's foot and either of the patient's visits. However, the Nurse Practitioner should have taken care to more accurately record his actions in dealing with this patient.

- A complainant alleged that nurses incorrectly withheld isophane insulin suspension (NPH) when patients' breakfasts were delayed. The complainant reasoned that the insulin starts its action later in the day, rather than immediately after its injection. Therefore, the complainant asserted that nurses should not wait until the patients have their breakfasts to administer it. The complainant did not identify a specific patient who may have been harmed by this practice. The exact time to administer insulin can depend on many factors, including the patient's response history, which physicians should take into consideration when ordering insulin. We noted that physicians did not specify the times to administer insulin injections. Many of the physicians' orders read, "in a.m." or "in p.m." instead of designating specific times. We reviewed medical records of eight patients who were receiving isophane insulin suspension or mixed insulin at the time of our visit. Nurses consistently administered insulin for these patients at about 6:30 a.m. and 5:30 p.m.

Issue 12: Credentialing, Privileging, and Training

We did not substantiate the following allegations pertaining to the credentialing and privileging, and training of clinical staff:

- A complainant alleged that some Intensive Care Unit nurses were not trained for critical care work, and did not pass the Intensive Care Unit examination. Although the complainant did not identify the individuals who were allegedly not trained and certified, we reviewed the personnel files of all 12 registered nurses and 6 licensed practical nurses who were assigned to the Intensive Care Unit. We found that all of the staff had the appropriate educational backgrounds and credentials. Intensive Care Unit orientation and in-service training records also showed that all of the nurses had received adequate training required to maintain their skills. Inspection of the results of a required Intensive Care Unit examination showed that all registered nurses passed the test. Our review also showed that all these registered nurses had current advance cardiac life support certifications.

- A complainant alleged that three nurses were inappropriately grandfathered into nurse practitioner positions. The six nurse practitioners, who were employed at the East Campus, completed an approved nurse practitioner program. Three of them possess Alabama Certified Registered Nurse Practitioner licenses, and the other three do not. However, East Campus managers appropriately grandfathered the three unlicensed nurses in accordance with VHA policy (IL-10-97-0241 dated July 7, 1997). VHA does not require a state nurse practitioner license in order to work as a nurse practitioner.

- A complainant alleged that untrained nurses were administering chemotherapy in the East Campus outpatient clinic. Outpatient nurses and physicians informed us that chemotherapy has not been given in the East Campus, including the outpatient clinic, for nearly 1 1/2 years. All chemotherapy is now being done at the West Campus. Currently, the only medication for cancer given at the East Campus is hormone therapy, which does not require special precautions.

Issue 13: Clinical Human Resources

We did not substantiate the following allegations of administrative and human resource issues pertaining to clinical employees:

- A complainant alleged that East Campus clinical managers removed a nurse from the Intensive Care Unit (ICU) even though she held national certification in intensive care nursing. An EEO investigation showed that the reason for her removal from the ICU was that she fostered a divisive influence, and other ICU nurses requested transfers if the nurse was not removed. Thus, the removal was an operational imperative that was intended to minimize disruption in a critical care environment. There is no guarantee that national certification in intensive care unit nursing will result in an ICU job. We concluded that the removal was appropriate.

- A complainant alleged that an East Campus registered nurse was inappropriately made to work temporarily in a medical unit other than her ICU assignment. OHI nurse consultants observed that nurses who normally work in intensive care units should be capable of working in a medical unit without formal orientation to the ward. This is particularly true if they are under supervision of another registered nurse on that unit. This is a common practice in private and public hospitals.

- A complainant alleged that East Campus managers would not give a registered nurse tuition reimbursement, or authorize an adjusted work schedule so that she could pursue a doctorate degree. The East Campus' tuition and education leave records for the nurse in question show that she applied for and received several tuition reimbursements between Spring 1992 and Spring 1995, for graduate level classes. The nurse's request for 12 months of educational leave of absence, which she submitted on August 2, 1996, was denied because she did not provide the requested documents delineating the specifics of her educational program and student status. The denial letter was signed by the CAVHCS Director, the Chief of Staff, the Chief, Human Resources Management Service, and the Acting Chief, Nursing Service. We identified one other instance in which managers declined the nurse's request to attend a continuing education program. In this instance, the denial was because the nurse was on sick leave at the time. Documentation for 1994 and 1995 shows that the nurse's course schedule did not conflict with her normal duty hours. Records also show that managers adjusted the nurse's duty schedule on August 21, 1996, so that she could pursue a doctorate degree.

- A complainant alleged that a nurse was receiving a uniform allowance and was also wearing medical center-supplied uniforms. We reviewed the nurse's personnel records, and interviewed her in order to explore this issue. We found that she did not receive a uniform allowance between September 22, 1991 and March 16, 1997. The nurse acknowledged she often wore surgical scrub suits similar to those provided by the facility. However, she said that she purchased these garments with her own funds.

Issue 14: Self-Initiated Reviews of QA/QM Procedures

In the course of OHI's review of the allegations and congressional concerns, inspectors encountered several issues that would normally fall within the province of quality management. These collateral reviews identified several areas which managers should rigorously address in order to improve patient care. In particular, medical center managers need to concentrate on improving performance on VHA's diabetes mellitus indicator monitors in order to approximate national standards. Clinical managers need to aggressively deal with patient falls and the most effective methods to prevent patients from falling. Other areas that inspectors reviewed appeared to function properly, or medical center clinicians corrected the problems identified during the inspection. We did not make any recommendations for any of the issues in this section since managers and clinicians were pursuing corrective actions.

Medical Center Diabetes Mellitus Management Needs to be Strengthened

OHI evaluated measures of diabetes mellitus (DM) management, collected through VHA's Chronic Disease DM Index for the East and West Campuses. VHA requires external peer reviewers to assess medical records of patients who have DM, for the presence of documentation that clinicians performed foot inspections, pedal pulse examinations, sensory examinations of feet, retinal eye examinations, and hemoglobin A1C (HbA1C). Inspectors found that clinicians on both campuses performed these procedures at substantially lower levels than VHA's national averages. However, clinical managers had initiated multidisciplinary efforts designed to improve compliance with these treatment parameters. These actions continued throughout OHI's inspection.

OHI inspectors reviewed East and West Campus' nurses' competency in using finger stick blood sugar monitoring equipment, because this is the procedure used to frequently monitor patients' blood sugar levels. OHI inspectors made unannounced visits to five nursing units during day and evening tours, and requested a registered nurse, on each unit, to demonstrate how to operate the finger stick blood glucose monitoring equipment. We found only one registered nurse, on a psychiatric unit, who could not properly demonstrate how to calibrate the finger stick glucose monitoring equipment. The laboratory supervisor informed us that the machine is configured so that it cannot be used unless it is correctly calibrated. Therefore, there is no possibility of obtaining an incorrect measurement owing to a wrong calibration. On West Campus the finger stick blood sugar monitor is calibrated by laboratory staff.

Managers Need to Strengthen the Medical Center's Fall Prevention Program

There is no standard VHA protocol that defines a reportable fall, a major injury, or an acceptable fall rate. At the West Campus all patients are required to be assessed at least weekly for their risks for falls. Compliance with this requirement ranged from 74 to 91 percent. The number of falls for each of the four quarters of Fiscal Year 1996 were as follows: 54, 30, 27, and 32, respectively, for a total of 143 patient falls. The

committee that is responsible for monitoring patient falls identified a need for stronger management support to proactively and aggressively hold accountable services that did not comply with patient fall precautions, but did not identify any patterns or trends to the falls. OHI inspectors concluded that the number of falls appear to be high when viewed against the low average daily census (ADC) which was 45-50 patients during that period.

At the East Campus, OHI inspectors cross-referenced documented falls in the medical records to determine if employees reported the incidents in the Patient Incident Reporting system. We concluded that employees generally appropriately completed incident reports when patients fell.

Inspectors focused on nursing employees' compliance with the established fall prevention program. We interviewed a total of five nursing employees from different units and reviewed the fall monitoring data for Fiscal Year 1993 through Fiscal Year 1996. We reviewed a test sample of medical records of patients who fell and sustained major injuries during Fiscal Years 1994, 1995, and 1996.

The review was conducted to determine if employees followed the fall prevention program requirements (Nursing Service Memorandum No. 118-94-8). This memorandum requires that Registered Nurses (RNs) assess patients for the presence of characteristics that predispose them to fall, such as a history of a previous fall; use of prosthetic devices; alterations in vision, hearing, and tactile senses; and use of central nervous system drugs. Points are awarded to each characteristic. These points are added and a final score determines one of three levels of nursing measures that should be implemented (Preventive, Modified, and Strict). CAVHCS policy requires RNs to assess patients on these criteria at the time of admission, after a fall occurs, and at other times as nurses deem appropriate. Issues identified during our medical record review included:

- RNs did not always complete assessments on admission;
- RNs did not always properly check existing fall criteria;
- Scores were added incorrectly, placing patients in the wrong risk categories;
- Nursing employees did not always implement or record preventive measures;
- Patients were not always re-assessed after falls;
- Patient/Family education was not recorded; and
- Outcomes of interventions were not documented.

OHI inspectors concluded that nursing employees did not consistently follow the fall prevention program. Inspectors also found that nursing employees did not have an adequate understanding or knowledge of the fall prevention program. They had difficulty verbalizing the procedures that they should follow to implement the fall prevention program. Neither campus had developed consistent and understandable definitions of what constitutes a reportable fall, a major injury, or an acceptable fall rate.

Random Sample of Re-admissions Within 3 Days of Discharge: East Campus

OHI inspectors reviewed a random sample of seven patients' medical records. The patients in this sample had been re-admitted shortly after they were discharged from the hospital. The sample covered the period from January 1 to March 30, 1997. The purpose of reviewing the occurrence screening factor was to determine whether the patients' discharges were appropriate.

These types of cases could highlight such problems as lack of discharge planning, misdiagnosis, lack of patient education, adverse drug reaction, wrong choice of treatment, or premature discharge. The latter is especially pertinent in this era of shorter length-of-stay policies. OHI inspectors did not elicit any questionable practices in this selected review.

Board Certification

Since complainants presented numerous allegations about substandard medical care, we examined the ratios of board certified physicians at each campus. The proportion of board-certified physicians in a facility is one indicator of a facility's' ability to provide adequate care. We found that 41 percent (22 out of 54) of the East Campus' physicians and dentists held board certification; and that 59.5 percent (25 out of 42) of physicians and dentists on the West Campus were board certified.

Neither campus has a board-certified geriatrician or a physician gerontologist. We did not find any instance in which patients did not receive adequate care because the facility lacked a board-certified geriatrician. Nevertheless, OHI believes that recruiting a physician with these skills would benefit the long-term care patients. The Under Secretary for Health recently emphasized a VHA goal to employ more board certified physicians. We support this effort.

Diabetes Mellitus/Associated Limb Amputation

OHI reviewed pertinent aspects of CAVHCS performance on selected quality measures for diabetes mellitus treatment. The need for DM patients' amputations may be associated with several factors including the natural progression of disease, poor patient compliance with prescribed treatment, clinical mismanagement, or combinations of these factors. OHI inspectors reviewed both campuses' amputation rates, and compared these rates with national and VISN averages. The patients who are attributed to a particular facility in the table were admitted to the facility immediately prior to their amputations. Data does not show that either campus' amputation rates significantly deviate from the national experience.

Fiscal Year 1996 Number of Amputations Per DM Population

Facility	Number Admitted for DM Care	Number of DM Patients who had Amputations (any limb)	% Amputees Per Admitted Diabetic Patient Population
West Campus	251	9	3.59%
East Campus	462	4	0.87%
VISN 7 Total	5,484	142	2.59%
VHA	92,202	2,559	2.78%

Pressure Sore Rate

A review of East and West Campus quality care indicators showed that pressure sore rates had increased at both campuses. East Campus employees intensified their efforts to address the increase in pressure sores, but it is too early to assess the effectiveness of these efforts. West Campus quality managers could not provide a reasonable explanation for the increase, but they are exploring the reasons and corrective options.

OHI inspectors concluded that there was a trend of increasing numbers of pressure sores in the last 2 years. Medical center managers recognized this trend in a timely manner and initiated a plan of action, including employing a cutaneous nurse specialist, on December 31, 1996 for the East Campus.

There was inadequate documentation of patients who were on special observations for suicidal precautions in the psychiatry units

Nursing standard practice requires that nursing employees closely monitor activities of patients at high suicide risk. During a visit to an East Campus psychiatry unit, OHI inspectors observed one patient who was assigned to a Special Observation Group (SOG) category. This patient's medical record showed that the patient was under close observation for suicide. However, the record did not contain any on-going documentation that nursing employees were closely observing the patient. Nursing employees simply wrote a brief summary, near the end of each shift, indicating that they had monitored the patient. Inspectors discussed this issue with the Chief, Psychiatry Service who agreed that a procedure was needed to record observations in a timely manner. Clinical managers submitted a procedure addressing this issue to OHI on September 16, 1997. We found that the new procedure adequately addressed this issue.

There was no policy or procedure requiring notification of targets of patients' homicidal intentions

In the course of reviewing medical records of East Campus psychiatric patients, inspectors found an instance in which a patient threatened to kill his ex-spouse. The

record contained a discussion, from a multidisciplinary team meeting, asserting that clinicians should notify the ex-spouse. However, there was no record indicating whether anyone actually notified the ex-spouse or when such a notification was made. This issue was discussed with the Chief, Psychiatry Service who agreed with inspectors that a policy is required to clarify responsibilities and procedures in carrying out notification. The Chief of Psychiatry Service submitted a procedure to OHI, dated September 15, 1997, "Procedure For Notification In Assaultive/Homicidal Threats." OHI concluded that this procedure addressed our concerns.

Crash Cart Readiness

At both campuses, OHI inspectors made unannounced visits to nine nursing units during the day and evening tours, to ascertain whether nurses were following policies governing periodic checking of crash carts. On each unit, inspectors asked one RN to demonstrate how he/she checked the readiness of the crash carts. We found that these nurses knew how to check the crash cart for completeness. However, the log books had many omissions, indicating that the crash carts were not checked on every shift as required or nurses did not consistently record this procedure. One West Campus ICU nurse could not demonstrate how to open the oxygen tank in the crash cart. Medical Center management should ensure that nurses check crash carts every shift as required by VA policy.

Patient-on-Patient Assaults (POPA): East Campus

POPA significantly increased from 39 such incidents in Fiscal Year 1995 to 62 in Fiscal Year 1996, in spite of a decrease in psychiatric beds. ***(b)(3)*** ***(b)(3)*** ***(b)(3)*** ***(b)(3)*** ***(b)(3)*** These actions resulted in a decrease of 16 such POPA incidents from 62 in Fiscal Year 1996 to 46 in Fiscal Year 1997.

Discharge Planning

OHI inspectors found that some patients' discharge plans were not fully implemented. An OHI inspector, who is a social worker, visited the East Campus on September 2-3, 1997, to review discharge-planning effectiveness in the long-term care bed services. We reviewed a random sample of 13 medical records of current inpatients occupying psychiatry, IMC, and Nursing Home Care Unit wards who had been hospitalized for more than 90 days, for evidence of active discharge planning. Three patients were awaiting transfers to the Nursing Home Care Unit, and seven patients were awaiting community nursing home (CNH) placement. Of the latter seven patients, two were

waiting for the VA to approve the CNH contract of their preferred nursing home. Three patients did not have any discharge plans completed.

The area surrounding East Campus is rural and isolated with relatively few long-term care options in the community. As a result of this the medical center has a history of hospitalizing patients for extended periods of time. In addition clinicians acknowledged that they are occasionally reluctant to pursue outplacement, because family members and patients routinely and vehemently resist discharge planning efforts. Social workers are attempting to change the prevailing attitude toward discharge planning, and patients or significant others are now asked to sign a statement that emphasizes that the extended care program is not intended to be a permanent housing alternative. We believe the CAVHCS Director should encourage an increase in the number of VA-approved community nursing homes.

OHI completed a CNH survey for nursing homes that had VA contracts (Report No. 7HI-A07-133, dated September 23, 1997). This report shows that Alabama VA medical centers had the lowest number of VA-approved CNH's (5 for the West Campus and 7 for the East Campus), whereas the average number of VHA-approved CNH's per VA medical center nationwide is 27.

Advance Directives

During our investigation of the "Do Not Resuscitate" issue, inspectors found that employees had apparent misconceptions about the meaning and purpose of Advance Directives (AD). VHA's AD program is designed to allow patients to state in writing, or orally, what treatments they desire to be done when they are incapable of making their wishes known. Only the patient is authorized to make an AD, although consultation with family members is encouraged. We found medical record entries such as, "The patient's wife has signed the AD," and "The son will come in to sign the AD." These entries clearly show that employees do not understand the basic AD principle that these are directives given by the patient, and not the family. These findings are consistent with prior OHI findings at other VA medical centers. (See Evaluation of the VHA's Advance Directive Program, OHI Report Number 7HI-A28-037, January 4, 1997).

PART V

GENERAL ADMINISTRATIVE CONCERNS

Issue 1: Personal Conduct of CAVHCS Service Chiefs

We received allegations, which we substantiated, that the Chief, ***(b)(6)***, Service at the West Campus operated a private business during his tour of duty, and that the former Chief, ***(b)(6)***, Service at the East Campus misused Government vehicles and misappropriated funds. We could not conclusively substantiate another allegation that the former Chief embezzled non-appropriated funds.

Allegation 1: The Chief, *(b)(6)*, Service at the West Campus operated a private business using Government resources and time.

We substantiated that the Chief, ***(b)(6)***, Service at the West Campus co-owned a private business and that, at his direction, the ***(b)(6)***, Service program assistant performed work for the business using a Government computer during her official duty time. According to the "Standards of Ethical Conduct for Employees of the Executive Branch," employees may not use, or allow the use, of Government property for other than authorized purposes, and must use official time in an honest effort to perform official duties. The program assistant told us she typed documents for the Chief, ***(b)(6)***, pertaining to his private business. She said she used the computer on her desk, and did so during her official duty hours. We obtained several documents prepared in late 1996 and early 1997 from the program assistant's computer pertaining to ***(b)(6)*** business. In addition, we found that, on one occasion, ***(b)(6)*** improperly used a Government cellular telephone to conduct his private business. The amount of the telephone call was negligible.

Allegation 2: The former Chief, *(b)(6)*, Service at the East Campus misused Government vehicles.

We substantiated that the former Chief, ***(b)(6)***, Service at the East Campus misused an official Government bus and automobile. In violation of VA regulations and Alabama law, the former Chief, ***(b)(6)***, used a 44-passenger bus from the East Campus interagency motor pool without a commercial driver's license, as required by VA regulations. In addition, ***(b)(6)*** did not document his use of the bus, which was used to drive ***(b)(6)*** home after work at the VA hospital. Both he and the motor pool supervisor told us that ***(b)(6)*** did not prepare trip tickets, as required, to document his mileage when he used the bus. We reviewed all available trip tickets for trips taken in the bus between September 1996 and March 1997 and found that ***(b)(6)*** completed only one. The motor pool supervisor told us he allowed ***(b)(6)*** to use the bus without completing trip tickets because ***(b)(6)*** told him it was not necessary for him to do so.

Regarding the Government automobile, we found that ***(b)(6)*** drove the vehicle approximately 27,000 miles without documenting its use. ***(b)(6)*** acknowledged to us that he did not complete the trip tickets. Without completed trip tickets, we were unable to determine when and where he drove.

Allegation 3: *(b)(6)* inappropriately issued *(b)(6)* paid from appropriated funds to his family members.

We substantiated that ***(b)(6)*** inappropriately issued ***(b)(6)*** paid from appropriated funds to his family members. ***(b)(6)*** are vouchers given to ***(b)(6)*** at the East Campus that they may redeem at the facility's ***(b)(6)*** or ***(b)(6)*** participating local ***(b)(6)***. ***(b)(6)*** are worth up to $3.95 each and are issued to individuals after they complete 4 hours of ***(b)(6)*** activities at the East Campus on a given day. We reviewed documentation of the ***(b)(6)*** redeemed in May, June, and July 1997 and found that six members of ***(b)(6)*** family redeemed a total of 117 tickets, at a total value of $423. However, our review of the daily sign-in log used by ***(b)(6)*** for the time in question disclosed only 32 instances in which a member of ***(b)(6)*** family earned a ***(b)(6)***. We concluded that there was no documentation to support the issuance of 85 ***(b)(6)*** to his family. Some of these were issued to a 6 year old and a 4 year old child who would not be in a position to do ***(b)(6)*** work. Furthermore, the proprietor of one of the participating ***(b)(6)*** told us she had seen ***(b)(6)*** use ***(b)(6)*** to buy his own ***(b)(6)***. During this review, ***(b)(6)*** retired. Because of the nominal value of the ***(b)(6)***, there was no interest in pursuing this matter criminally. Management should review the amount of ***(b)(6)*** that were inappropriately used by ***(b)(6)*** and his family, and issue a bill of collection to the former employee to recover the expenses.

Unsubstantiated allegation

We did not substantiate the following allegation regarding ***(b)(6)***:

- A complainant alleged that ***(b)(6)*** embezzled over $2,000 intended to benefit veterans. The money ***(b)(6)*** allegedly took represented proceeds from the sale of popcorn at the East Campus. ***(b)(6)*** was responsible for delivering cash proceeds from the sales to a member of the VA ***(b)(6)*** Service Executive Committee for deposit into a non-VA account. The OIG Office of Investigations presented this matter to the Assistant U.S. Attorney, who declined to prosecute ***(b)(7)(E)***.

Conclusion

The Chief, ***(b)(6)*** Service at the West Campus directed the Service's program assistant to perform work for his private business using a Government computer during her official duty time. In addition, the former Chief, ***(b)(6)*** Service at the East

Campus used an official Government bus without a valid driver's license and without properly documenting its use. He failed to document his use of a Government automobile. There was also some evidence, which showed that the former Chief inappropriately issued ·***(b)(6)***· · · · · · · · ·paid from appropriated funds to himself and his family members.

Recommendation 16

The Director, CAVHCS, should:

a. Take appropriate administrative action against the Chief, ·***(b)(6)***· · · · · Service at the West Campus for misusing Government property and official time to conduct a private business.

b. Ensure that East Campus motor pool employees require all drivers of Government vehicles to complete trip tickets each time they use such vehicles.

c. Ensure that all drivers of Government vehicles possess the appropriate driver's license.

d. Review the amount of inappropriate ·***(b)(6)***· · · · · · · · ·the former Chief, ·***(b)(6)***· · · · · ·Service, East Campus, administered to himself and his family, and issue a bill of collection to the former employee.

VHA Comments

The Chief Network Officer concurred with all the above recommendations and noted actions taken to address the concerns. His complete comments are in Appendix B.

OIG Response

The Chief Network Officer's comments were responsive to the recommendations. We consider the issues resolved.

Issue 2: Staff Use of Charge Cards for Official Business

We received an allegation, which we substantiated, that certain employees at the East Campus misused the Government American Express cards issued to them. We received other allegations, regarding misuse of IMPAC cards, which we did not substantiate.

Allegation 1: East Campus staff misused their Government American Express cards.

We substantiated that 10 of 13 staff at the East Campus alleged to have misused their Government American Express cards made inappropriate purchases with their cards and/or failed to pay the full balance due in a timely manner. We reviewed monthly activity reports provided by American Express, as well as travel and time and attendance records, from October 1994 through June 1997, and found that six of the named staff made inappropriate purchases. Furthermore, we found that, prior to October 1994, American Express cancelled cards belonging to four of the named staff because they failed to pay their full balances due. The remaining three staff either were never issued a Government American Express card, or did not misuse their cards during the time period we reviewed. VA employees may use their Government American Express card for official purposes only while they are on official travel. All other purchases made during official travel must be made with cash or personal credit.

The six employees who made inappropriate purchases are discussed below:

- ***(b)(6)*** used her card to obtain cash for personal business on 49 occasions, receiving a total of $9,074. On one occasion she also used her card to make a personal purchase of $406. ***(b)(6)*** acknowledged to us that the transactions were for personal reasons, not associated with official travel. She told us that, although management never discussed the matter with her, she was aware at the time that she inappropriately used the card.

- ***(b)(6)*** used her card on 9 occasions for personal reasons, purchasing items totaling $1,700. Four of the charges, accounting for $1,239, were for the rental of a car for personal transportation. A fifth purchase, for $201, was for a new set of tires for her car after one went flat while she was traveling on official business. ***(b)(6)*** made additional purchases with her Government American Express card for personal souvenirs while on official travel. The former Associate Director at the East Campus told us he talked to ***(b)(6)*** about the inappropriate use of her card, and instructed her service chief to monitor the situation.

- ***(b)(6)*** made 10 inappropriate charges using her Government American Express card, which totaled $1,187. Eight of the charges, accounting for $1,173, were incurred in February and March 1996 in connection with a professional

conference ***(b)(6)*** attended in another city. ***(b)(6)*** maintained that those charges were not of a personal nature, and that she did not misuse her card. However, she did not have a travel authority to attend the conference, and she was on annual leave at the time. Therefore, we concluded the charges were of a personal nature and should not have been made on her Government American Express card.

- The remaining three employees misused their Government American Express cards by making personal purchases from retail establishments. ***(b)(6)*** made 11 inappropriate charges amounting to $970, including purchases at a local shoe store and a purchase of software for her personal computer. ***(b)(6)*** made 4 inappropriate charges amounting to $377, including the purchase of souvenirs while she was on official travel. ***(b)(6)*** made 3 inappropriate charges totaling $119, including charges for clothing.

According to the former ***(b)(6)*** and the former Associate Director of the East Campus, in general, they only became concerned if an employee failed to pay the full balance due on their American Express bill. In such instances, the former ***(b)(6)*** said he alerted the Director, Associate Director and Chief of Staff so they could take action. The former Associate Director told us he did not become too concerned about small purchases that appeared to be inappropriate, as long as the employee paid for them when the bill came due. However, since VA regulations prohibit employees from using Government American Express cards for any personal purchases, the former Associate Director should have taken such misuse more seriously.

In addition to the above six employees, four others had their cards cancelled by American Express for failing to pay the balance due. One employee was terminated in part because of her misuse. A second employee received an admonishment, and the remaining two employees, according to the former Associate Director, were verbally counseled.

Unsubstantiated allegations

We did not substantiate the following allegations pertaining to East Campus employees' misuse of IMPAC cards. IMPAC cards are issued to certain staff as an expeditious means for them to make small official purchases.

- A complainant alleged that an East Campus service chief exceeded the dollar limit of the IMPAC card issued to him. We found that no IMPAC card had been issued to the service chief. We also reviewed the monthly statements from December 1995 through July 1996 for the one card issued to the service in question, and found no evidence that the maximum limit had been reached or exceeded. We were told that since March 1997, Acquisition and Materiel Management Service employees have maintained physical possession of all IMPAC cards.

- A complainant alleged that an East Campus employee used her IMPAC card to purchase gasoline for a personal vehicle. We reviewed IMPAC card statements to determine if a purchase was made at the gas station in question, and found no such purchase. Further, an employee of the gas station the employee allegedly made her purchase from told us the business did not accept credit cards.

Conclusion

Ten staff at the East Campus misused their Government American Express cards by making inappropriate purchases and/or failing to pay the full balance due in a timely manner.

Recommendation 17

The Director, CAVHCS, should:

a. Take appropriate administrative action against those employees discussed above who misused their Government credit card, if such action has not already been taken.

b. Develop a review process whereby inappropriate Government credit card purchases are detected and reported to management.

c. Remind all staff who have been issued Government credit cards that they may be used only while on official travel, and only for official purposes.

VHA Comments

The Chief Network Officer concurred with all the above recommendations and noted corrective actions taken. Regarding recommendation 17.a., he also stated that the Acting Director, CAVHCS, will review all local procedures to ensure that employees provided Government travel cards in the future are trained as to their proper use. The Chief Network Officer's complete comments are in Appendix B.

OIG Response

The Chief Network Officer's comments were responsive to our recommendations. We consider recommendations 17.b. and 17.c. resolved, and will follow up to ensure the planned action relative to recommendation 17.a. is implemented.

Issue 3: Employee Time and Attendance Practices

We received allegations that an East Campus timekeeper for the Nursing Service was fraudulently posting overtime. While we did not substantiate this allegation, we did find vulnerabilities in the recording of overtime. Furthermore, we substantiated that East Campus Nursing Service staff took excessive sick leave, and that management did not adequately monitor such use. We did not substantiate specific instances of alleged time and attendance abuse by two employees outside the Nursing Service (one at the East Campus and one at the West Campus).

Allegation 1: Procedures for recording overtime at the East Campus allow abuse.

To review allegations of fraudulent posting of overtime at the East Campus, we tracked the recording and payment of overtime for six Nursing Service staff from the last pay period in 1995 through the 12th pay period in 1997. We reviewed hand written ward time sheets, employees' time cards, time and attendance records, and the electronic supervisory approvals of overtime worked. While we did not substantiate allegations of abuse, we determined that the process was susceptible to abuse because procedures were not always followed. We found instances in which supervisors' electronic approvals of overtime worked were not recorded until days after overtime was paid, instances in which no electronic supervisory approval of overtime paid was recorded, and instances in which nursing staff were certifying their own overtime.

Also while reviewing the alleged fraudulent posting of overtime, we noted that, for two of the six Nursing Service staff, compensatory time was approved even though the employees had not earned any compensatory time. We found that, during the period under review, one employee used 3.5 hours of compensatory time, which she had not earned, and the second employee used 5.0 hours of compensatory time she had not earned. We brought this to the attention of Fiscal Service staff, and they prepared corrected time cards for the two employees and charged them annual leave for the hours in question.

Allegation 2: East Campus Nursing Service staff took excessive sick leave.

We substantiated that East Campus Nursing Service staff took excessive sick leave, and that management did not adequately monitor such use. From the last pay period in 1995 through the 12th pay period in 1997, Nursing Service staff at the East Campus used 87 percent of the sick leave they earned. We reviewed time and attendance records for 26 randomly selected staff who used more than one year's worth of sick leave earned (104 hours) during this time. Over half the full sick leave days these staff took were immediately before or immediately after a regularly scheduled day off.

According to East Campus policy (Memorandum No. 05-95-23, February 1, 1995), which Nursing Service officials told us applied to the Nursing Service, if an employee "has used more than four days of sick leave…during a six-month period, and sick leave

abuse is suspected, the employee may be given a letter of counseling." If there is no improvement, the supervisor may require the employee to provide a physician's certification for future uses of sick leave. While the former Acting Chief, Nursing Service acknowledged that the sick leave use statistics indicated an abuse problem, she told us none of the 26 employees we identified had been placed on sick leave restrictions. She said that head nurses were supposed to monitor sick leave use but not all of them did.

One complainant suggested that Nursing Service managers routinely provide staff insufficient time off between shifts, and that this was one reason employees took such a high rate of sick leave. However, we found that this was not the case. For the 26 staff we randomly selected, we tracked every regularly scheduled shift they worked during the time period reviewed to determine if they had less than 8 hours off between shifts. Of the 9,400 shifts we examined, we found only 47 instances in which an employee was scheduled to return with less than 8 hours off. Further, of these 47 instances, the affected employee used sick leave only twice.

Unsubstantiated allegations

We did not substantiate the following allegations pertaining to time and attendance abuse:

- A complainant alleged that an East Campus timekeeper for the Nursing Service fraudulently posted overtime hours that were not worked for six staff in return for cash and gifts. Our review of overtime records, noted above, disclosed that there were only two instances (one half hour each) in which one of the six employees received overtime that was not supported by subsidiary timekeeping documents. We also reviewed medical records to verify that one of the six nurses (who was given the highest amount in overtime pay) actually worked on the ward on ten occasions when she was recorded as working overtime. In each instance, we found evidence that the nurse was on the ward. We interviewed nine Nursing Service staff who earned high amounts of overtime pay from the last pay period in 1995 through the 12th pay period in 1997. They testified that they never received overtime pay to which they were not entitled, and that the timekeeper never offered them unearned overtime hours. The timekeeper denied to us the allegation, and an allegation that he attempted to bribe an employee by offering her overtime in return for her silence on an error he allegedly made.

- A complainant alleged that no corrective action was taken following the issuance of a Spring 1994 task force report on overtime problems in the East Campus Nursing Service. According to the former Associate Director and one of the task force members, the task force never submitted a formal written report. The former Associate Director recalled a verbal briefing, with documentation, that was provided by the chairperson of the task force, but could not recall any specific concerns. The chairperson had retired and we could not identify or obtain any documentation associated with this review.

- A complainant alleged that an administrative employee worked a considerable amount of overtime in late 1995 and early 1996, without justification. We reviewed the employee's time and attendance statements from October 1, 1995 through January 4, 1997, when the employee retired. According to those documents, the employee worked overtime on only one occasion, for 2 hours, performing work for Regional Counsel.

- A complainant alleged that a West Campus employee left work early on 42 occasions, and was not charged leave. We reviewed the employee's time and attendance record covering the dates in question and found that the employee charged leave on 39 of the 42 occasions. The employee told us that he reviewed his personal records and did not believe he left early on the remaining 3 days.

Conclusion

Weaknesses exist in the procedures for recording overtime in the East Campus Nursing Service. Although our review did not identify significant instances of employees receiving overtime pay for time not worked, the weaknesses we identified could allow this to occur. During our review, we found two employees who used compensatory time they had not earned. We also found a high percentage of sick leave use within the Nursing Service and a pattern of sick leave being taken immediately before or after a regular day off. Further, we found that Nursing Service managers needed to improve efforts to monitor sick leave use.

Recommendation 18

The Director, CAVHCS, should ensure that supervisory Nursing Service staff at the East Campus:

a. Properly approve and certify overtime worked by staff.

b. Monitor sick leave use and implement appropriate corrective measures when sick leave abuse is suspected or found.

VHA Comments

The Chief Network Officer concurred with the above recommendations, and stated that corrective actions have been taken to implement them. His complete comments are in Appendix B.

OIG Response

The Chief Network Officer has taken action responsive to our recommendation and we consider the issue resolved.

Issue 4: Purchases and Contracts

We received an allegation, which we substantiated, that the East Campus paid more than they should have for three refrigerators purchased for their Nursing Home. We also received several additional allegations of questionable purchases and contracts made by both the East and West Campuses, which we did not substantiate.

Allegation 1: The East Campus paid more than they should have for three refrigerators.

We substantiated that three refrigerators purchased by the East Campus through its Canteen Service could have been bought at a lower cost. The refrigerators were intended to store snacks, nourishments, and desert items for patients in the Nursing Home, as well as for employee use. They were black on black color, 19.7 cubic foot, side-by-side refrigerator/freezer units with a water and ice dispenser in the door. Each refrigerator cost $1,620. At about the same time these three refrigerators were purchased, the West Campus purchased a white color, 25.7 cubic foot, side-by side refrigerator/freezer unit with water and ice dispensers in the door. However, they paid only $1,088 for this unit.

According to the purchasing agent responsible for the purchase of the three Nursing Home refrigerators, he purchased the units because the former Acting Chief, Nursing Service told him they were the ones she wanted. He noted that he did contact two additional sources as required, one a local retailer and the other a contractor, but found the retailer's price too high and the contractor unable to provide a refrigerator as described above. The former Acting Chief, Nursing Service told us she selected the refrigerators during a telephone discussion with the purchasing agent, who suggested buying black refrigerators. She said she was not knowledgeable about refrigerators and did not know that black ones were more expensive. We concluded that the purchasing agent should have known that designer color refrigerators cost more, and should have obtained the most economical ones.

Unsubstantiated allegations

We did not substantiate the following allegations regarding questionable purchases and contracts at the East and West Campuses:

- A complainant alleged that the former Chief, Environmental Management Service at the East Campus purchased 2,000 bottles of body shampoo even though they had 1,000 bottles on hand. We identified five purchases of body shampoo from the Service's fund control points between January 1995 and August 1996. None indicated that the item was purchased in the quantity alleged.

- A complainant alleged that the Chief, Environmental Management Service at the West Campus purchased expensive designer shoes for his friend. We reviewed all shoe purchases made by the Environmental Management Service in fiscal years

1996 and 1997. We found one instance in which special shoes were ordered. A prosthetics employee received a pair of black dress safety shoes, costing $83. It was purchased from a contract source, at the request of the Chief, Prosthetics Service, for the Prosthetics Service employee. The administrative assistant in Environmental Management Service told us the shoes had steel toes and came from the same catalog she used to buy standard safety shoes. She said the employee was entitled to receive protective clothing, including safety shoes, because he worked around heavy items.

- A complainant alleged that the Chief, Prosthetic and Sensory Aids Service at the West Campus purchased 14 special hospital beds, most of which were not needed. We reviewed the Prosthetic and Sensory Aids Service's purchases of hospital beds since October 1996, and found that they typically purchased electric beds costing $586. We identified one bed that appeared different. The bed cost $5,475 and was designed to hold the weight of an excessively obese patient.

- A complainant alleged that the Laboratory Service at the West Campus obtained new chemical analyzers that were not needed and were not compatible with the analyzers being used at the East Campus. According to the purchase document, the West Campus does not own the equipment, but pays the vendor a certain amount per test conducted. The Chief, Laboratory Service and the laboratory manager told us that the new analyzers are faster, cheaper, and more flexible than the one the West Campus had previously. The laboratory manager also stated that, for a majority of the tests, the new analyzers are compatible with the one at the East Campus.

- A complainant alleged that the Chief, Engineering Service at the West Campus contracted for plumbing services to avoid hiring a full time employee, and used a particular contractor more than others because the Chief belonged to the same labor union as the contractor's employees. The Chief, Engineering Service told us that about 3 years ago he had several vacant skilled trade positions, including a pipe-fitters position. The pipe-fitters provided plumbing services for the facility. The Chief told us that, at that time, management allowed him to fill only one of these positions. The Chief decided to hire an electrician because he felt that was the greatest need, and began contracting for plumbing services. We reviewed 95 purchase orders for plumbing services issued by the West Campus during fiscal years 1995, 1996, and 1997, and found that 85 of them were issued to one contractor. The Chief told us this contractor was extremely reliable, did quality work at a reasonable price, and that other contractors often declined to service the facility. The Chief told us he was not a member of the same union as the contractor's employees. In fact, he said he did not belong to any trade union.

- A complainant alleged that Acquisition and Materiel Management Service staff did not follow proper procurement procedures when contracting for staffing at an East Campus outpatient clinic. We found that a prospective bidder alleged East Campus staff did not provide appropriate information in addition to the specifications included

in the solicitation. The issue was referred to VA's Office of General Counsel and, on their advice, the solicitation was canceled and another one advertised. We found no evidence of employee misconduct regarding this matter.

Conclusion

The East Campus could have saved almost $1,600 on the purchase of three refrigerators if they had bought the most economical ones available that met their needs.

Recommendation 19

The Director, CAVHCS, should ensure that purchasing agents obtain the most economical items, and do not pay extra for unnecessary amenities.

VHA Comments

The Chief Network Officer concurred with the recommendation and noted that policies and procedures have been implemented to ensure appropriate purchasing practices are followed for all purchases. The Chief Network Officer's complete comments are in Appendix B.

OIG Response

The comments were responsive to our recommendation, and we consider the issue resolved.

Issue 5: Safety, Cleanliness, and Equipment

We received allegations, which we substantiated, that fire and smoke alarm systems at the East Campus did not function properly and that the canteen at the East Campus had not recently been inspected for cleanliness. We did not substantiate other allegations regarding the operation of various equipment items.

Allegation 1: Certain fire and smoke alarm systems at the East Campus did not function properly.

We substantiated that certain fire and smoke alarm systems at the East Campus did not function properly. We observed the operation of fire and/or smoke alarms and doors on two occasions. In the first instance, the Assistant Chief, Engineering Service accompanied us to an unoccupied floor of a building where we observed that the devices intended to close two fire doors had been removed, and one of the doors was propped open. The Assistant Chief could not explain why the devices were removed. He did not consider this a problem because the floor was not occupied. However, occupants were elsewhere in the building. According to the Fire Department Chief, the fire and smoke alarm systems must meet requirements of the National Fire Protection Association. These requirements state that, for fire and smoke barrier doors, "a closing device shall be installed on every fire door" and "the closing device shall not have a hold-open feature."

In the second instance, we observed the operation of three fire doors in another building. When the Fire Department Chief activated a nearby smoke detector, the alarm sounded, warning lights flashed, and the fire doors closed. However, while the alarm was still active, one of the doors was manually opened, and stayed open instead of immediately closing. The Fire Department Chief reset the system and again activated the smoke detector. Again, the door failed to automatically close after it was manually opened. The Fire Department Chief acknowledged that the fire door should not have remained open. The Fire Department Chief then activated the fire alarm. The alarm sounded, warning lights flashed, and the three doors closed once again. While the alarm was still active, a fire door was manually opened. In this instance, the door closed immediately when released, as it should have.

We reviewed the Fire Department's 1996 and 1997 monthly inspection reports for four East Campus buildings. The reports for two of the buildings, including the building whose fire doors we observed did not automatically close, repeatedly cited the need for door repairs. We found eight monthly reports citing the need for fire door repairs between March and December 1996. We reviewed work orders that indicated the fire doors were repaired. However, within 2 months following each repair, another report again cited a deficiency. The Fire Department Chief could not explain why this occurred.

The Fire Department Chief told us that his inventory of fire alarm boxes is not complete. Therefore, he had no assurance that every box was tested and working properly. He

stated that when his staff find a new fire alarm box they add it to the list. He also stated that the East Campus did not start maintaining an inventory of all smoke detectors until January 1997. He could offer no assurance that the smoke detectors were routinely tested, as required by the National Fire Protection Association, before he started to keep an inventory.

Allegation 2: The East Campus has no recent documented cleanliness inspections of its canteen.

We substantiated that there have been no documented bacteriological inspections of the East Campus canteen since November 1994. The Veterans Canteen Service requires facility directors to ensure that satisfactory and sanitary conditions are maintained in the canteens. The Chief, Canteen Service is responsible for requesting periodic bacteriological examinations and tests of the efficiency of sanitizing methods used on dishes, flatware, equipment, and food preparation utensils. The November 1994 inspection, performed by the facility's infection control practitioners, documented several cleanliness issues. The only other canteen inspection we could identify was performed in August 1995 by Environmental Management Service staff. This was not a bacteriological inspection. The former Acting Chief, Environmental Management Service and the Chief, Canteen Service both told us that Environmental Management Service had made informal inspections of the canteen since August 1995. However, they had no documentation of those inspections.

Unsubstantiated allegations

We did not substantiate the following allegations regarding the operation of certain equipment:

- A complainant alleged that no boiler back-up system existed at the East Campus. We toured the boiler plant and observed that there were three boilers. The boiler operator told us that during the summer, only one boiler is typically in operation, and the other two function as back-ups. He stated that during the winter, two boilers are typically in operation, and the remaining one serves as the back-up. The operator told us that when a boiler breaks down, it is repaired within 24 hours. He stated a boiler needs only one half hour to become fully operational because the water is maintained at a warm temperature even when the boiler is idle. We reviewed 1996 and 1997 records indicating which boiler(s) were in operation and which were functioning as a back-up. The records supported the information provided by the boiler operator.

- A complainant alleged that the bulk oxygen storage tanks were not properly secured and that air distribution system alarms were not operating correctly. We observed the two bulk oxygen storage tanks and found each to be protected by a chain link fence and/or a brick wall. The tanks' legs were secured into concrete with bolts. According to the Engineering Service's Chief, Biomedical Section, several tornadoes and one major hurricane have affected the area over the last few years, but the

tanks have remained secure. Regarding the air distribution system, a private contractor tested the medical gas piping systems (oxygen, nitrous oxide, compressed air, and vacuum systems) in January 1997 and cited three deficiencies. According to the Chief, Biomedical Section, the deficiencies had been, or were in the process of being, resolved. Another private contractor reviewed the master alarm system in November 1996 and again in June 1997, and found no problems.

Conclusion

Certain fire and smoke alarm systems at the East Campus did not function properly. In addition, East Campus Fire Department officials did not know the location of all fire alarm boxes. If an unknown fire alarm box is activated, the Fire Department will not know where to respond. Regarding the East Campus canteen, no documented bacteriological inspections had been made since November 1994.

Recommendation 20

The Director, CAVHCS, should ensure that:

a. All malfunctioning fire doors at the East Campus are repaired, and all fire alarm boxes identified.

b. Bacteriological inspections of the East Campus canteen are performed and documented to ensure sanitary conditions.

VHA Comments

The Chief Network Officer concurred with the above recommendations and indicated that corrective actions have been initiated, or are planned. His complete comments are in Appendix B.

OIG Response

The actions initiated or planned are responsive to our recommendation. We will follow up to ensure that all actions are implemented.

Issue 6: Preferential, Discriminatory, and Derogatory Actions, and Complaint Resolution Processes

While conducting this inquiry, we found that a nurse at the East Campus made an anti-Semitic remark about the OIG staff. Regarding complaint resolution processes, we substantiated that staff at the West Campus were not processing EEO complaints in a timely manner. In addition, we substantiated that the Patient Representative did not follow-up to ensure that patient complaints at the East Campus were resolved.

Allegation 1: A nurse at the East Campus made an anti-Semitic remark about the OIG staff.

We found that a nurse-instructor at the East Campus made an anti-Semitic remark during an in-service training class. The instructor told class participants that the OIG staff were "New York Jews in three-piece suits." When we asked the instructor if she made the remark, she acknowledged that she did and said she knew that it was inappropriate.

Allegation 2: EEO complaints at the West Campus were, until recently, not processed in a timely manner.

We substantiated that EEO complaints at the West Campus were, until recently, not processed in a timely manner. In January 1997, the EEO programs at the two campuses were combined and East Campus staff began managing the West Campus' program. The EEO Program Assistant at the East Campus told us that, at the time the programs were combined, most staff serving as EEO counselors at the West Campus were not properly trained, a backlog of complaints existed, and some cases filed at the West Campus were not properly followed-up. However, she told us that recent efforts have eliminated the backlog of cases and that training was being provided to the EEO counselors.

Allegation 3: Prior to 1997, the Patient Representative at the East Campus did not follow-up to ensure that patient complaints were resolved.

We identified several complaints made by patients at the East Campus between March 1995 and January 1997 which the Patient Representative did not ensure were resolved. The Patient Representative acknowledged that, in the past, when he referred a patient complaint to management for their resolution, he generally did not follow up to ensure that appropriate action had been taken. However, the Patient Representative told us that since January 1997, as the result of a Congressional inquiry, he has been conducting a thorough follow up on the outcome of complaints he refers to management and supervisory staff.

Unsubstantiated allegations

We did not substantiate the following allegations of unfair, discriminatory, and derogatory actions at the West Campus:

- A complainant alleged that two nurses made racially disparaging remarks. Allegedly, an African-American nurse, referring to a Caucasian patient, told other staff that "she wished she had a deer rifle, that she would put a bullet right between his eyes", and that "she can't stand having him look at her." The second nurse allegedly remarked that "when a white person married a black the white genes caused the black child to be very ugly and mentally retarded." According to the complainant, three supervisors were told about these statements but took no action against the two nurses. We were not able to interview the nurses alleged to have made the remarks or two of the three supervisors because they no longer worked at the CAVHCS. We did interview the one remaining supervisor. She stated she was never told that the remarks were made. We also interviewed 22 nursing staff, to find out if they had witnessed nurses making disparaging remarks about patients at the East Campus. The staff told us they had not witnessed any such remarks.

- A complainant alleged that he was unfairly prevented from applying for the position of Chief, Supply Processing and Distribution Section because the former Chief, Acquisition and Materiel Management Service advertised the position as a GS-10 whereas it previously had been advertised as a GS-5/7/9. The former Chief, Acquisition and Materiel Management Service told us the position changed substantially since it was last filled many years ago, and now has a more important function in patient care support. The former Chief said he needed someone with technical, as well as management experience and that the position was not suited for a trainee. He told us he wrote a position description detailing the elements he believed were essential and submitted it to Human Resources Management Service staff, who assigned it a grade level of GS-10.

- A complainant alleged that two Caucasian employees received preferential treatment when they were selected for their positions. One individual allegedly was selected for a Nurse Executive position even though her official personnel file did not document that she had the required education. The Nurse Executive position requires a Masters Degree. We reviewed the selectee's official personnel file and found a copy of her transcripts, which confirmed that she did have the requisite degree. The second employee allegedly did not have the required credentials to be a Grade II Registered Nurse. We reviewed this employee's official personnel file and found that she had an Associate Degree in nursing and held a current Alabama license as a Registered Nurse. According to the OIG's Office of Healthcare Inspections staff, the nurse had proper credentials for the position.

- A complainant alleged that a Caucasian nurse unfairly received a higher starting salary than did an African-American nurse. We reviewed the nurses' official personnel files and found that the starting salary of the Caucasian nurse was $1,025

greater per year than the starting salary of the African-American nurse. However, the Caucasian nurse had 17 years of work experience at the time she was hired, whereas the African-American nurse had 9 years of experience. The additional experience justified the additional salary. We reviewed another similar allegation and found that both nurses were hired at the same pay, but the African-American nurse advanced in rank and pay more rapidly.

- A complainant alleged that a Caucasian nurse who had a substance abuse problem was given preferential treatment compared to an African-American nurse who had a similar problem because the Caucasian was allowed to participate in an assistance program, whereas the African-American was not. An Employee Relations Specialist told us the Caucasian acknowledged she had a substance abuse problem, enrolled herself in an accredited rehabilitation program approved by the Alabama State Nursing Association, and successfully completed that program. The Employee Relations Specialist told us the African-American nurse never requested assistance. The complainant also alleged that the Caucasian stole money from a patient. We reviewed the West Campus' police records and found no evidence that such a theft was reported.

Conclusion

A nurse at the East Campus made an anti-Semitic remark. Problems did exist in the West Campus' EEO complaint processing system and in the East Campus' patient complaint system. However, the problems were resolved.

Recommendation 21

The Director, CAVHCS, should take appropriate administrative action against the East Campus nurse who made an anti-Semitic comment.

VHA Comments

The Chief Network Officer concurred with our recommendation, but stated that the nurse in question has retired and no further action will be taken. The Chief Network Officer's full comments are in Appendix B.

OIG Response

We consider this issue resolved.

Issue 7: Administrative Staff Approving Inappropriate Inpatient Admissions and Outpatient Services

While reviewing allegations that East Campus staff permitted inappropriate inpatient admissions and outpatient services, we found that the facility's Hoptel policy did not provide the flexibility to accommodate veterans needing more than an overnight stay. We did not substantiate allegations regarding ineligible inpatient admissions, inappropriate care provided to non-veterans, and an inappropriate length of stay in the Homeless Domiciliary, at the East Campus.

Allegation 1: The East Campus Hoptel policy did not provide the flexibility to accommodate veterans needing more than an overnight stay.

We found that the East Campus Hoptel program, which was designed to provide short-term lodging to veterans and their family members or caregivers under certain conditions, did not allow veterans with legitimate needs to have extended stays. According to East Campus policy, veterans may stay in the Hoptel overnight if they have to travel long distances or are affected by inclement weather. The policy also allows caregivers who accompany a veteran to stay overnight for the same reasons. One caregiver accompanying a patient may stay in the Hoptel. If a patient is critically ill two family members, other than the caregiver, may stay for up to three nights for a nominal charge. We identified some instances in fiscal year 1997 in which veterans had long term stays at the Hoptel. For example, one veteran had a continuous stay in the Hoptel for 20 days because he lacked transportation. Another veteran had continuous lodging for 34 days so that he could attend therapy twice a week, and a third veteran had continuous lodging for 28 days for an unknown reason. We believe consideration should be given to changing the Hoptel policy to include circumstances which may qualify persons for extended stays.

Unsubstantiated allegations

We did not substantiate allegations regarding ineligible inpatient admissions, inappropriate care provided to non-veterans, and an inappropriate length of stay in the Homeless Domiciliary, all at the East Campus.

- A complainant alleged that an individual who was not a veteran received inpatient care at the East Campus. According to the individual's medical record and administrative file, the patient was a World War II veteran entitled to VA medical care.

- A complainant alleged that the father of the former Chief of Staff improperly received inpatient care at the East Campus. We found no evidence indicating that the father, or the Chief of Staff himself (who had the same name), was ever admitted.

- A complainant alleged that an ineligible patient was admitted at the East Campus as a lodger and remained for more than 30 days. We found that the veteran was a Medal of Honor recipient and entitled to care. According to documentation provided to us, the Chief of Staff determined that the veteran, who lived a great distance from the East Campus, required daily physical therapy and that the therapy could be provided more economically by the East Campus than by a contractor. Also, according to the former Chief of Staff, daily trips to the East Campus would have caused a significant hardship for the veteran. The Chief of Staff decided that he would allow the veteran to remain at the East Campus as a lodger.

- A complainant alleged that non-veterans inappropriately received medical treatment at the East Campus. According to the East Campus' "Veteran Eligibility and the Furnishing of Health Care" report for Fiscal Years 1995, 1996, and January through June 1997, the East Campus made 7,490 admissions for inpatient care during this time, including 7,410 Category "A" patients and 80 Category "C" patients. No non-veterans were admitted. We did find that non-veterans obtained outpatient care, but did not identify any that did so inappropriately. According to the "Ambulatory Care Program Means Test Outpatient Visit Summary" for the same time period, there were 15,488 outpatient episodes (7.6 percent of the total number of episodes) involving non-veterans. For example, non-veteran employees and regularly scheduled volunteers are entitled to care for on-the-job injuries and health maintenance (such as flu shots and blood pressure checks) from the Employee Health Unit. These visits are recorded as outpatient episodes. At the time of our review, 2,513 individuals had received treatment in the Employee Health Unit. Non-veterans may also appropriately receive care if they are in the CHAMP-VA program, or for humanitarian reasons.

- A complainant alleged that about 45 reservists received unauthorized blood work in 1992 or 1993. We found that, under an agreement with a local military hospital, the East Campus provided support for training reservists. According to an officer in that reserve unit, training exercises took place during the time in question and reservists were processed through the East Campus ambulatory care area. She told us that the reserve unit provided its own staff and supplies.

- A complainant alleged that a "Ms. Johnson" was allowed to stay in the Homeless Domiciliary Program for 6 months and that, when she left, East Campus staff helped move her. We reviewed a list of all patients enrolled in the program from June 1996 through September 1997 with a length of stay exceeding 90 days, and found none with the name of Johnson. Also, several people we spoke to on the ward could not remember anyone named Johnson.

Conclusion

The East Campus Hoptel policy did not provide flexibility to accommodate veterans needing more than an overnight stay.

Recommendation 22

The Director, CAVHCS, should determine under what circumstances patients and or their caregivers would qualify for extended stays in the Hoptel, and if appropriate change the existing Hoptel policy.

VHA Comments

The Chief Network Officer concurred with the recommendation, and noted that an updated Medical Center Memorandum addressing this matter was issued. His complete comments are in Appendix B.

OIG Response

The action taken was responsive to our recommendation and we consider the matter resolved.

Issue 8: Disposition of Properties Removed From the West Campus

We substantiated the following allegation:

Allegation 1: A supervisor improperly removed confidential documents from the West Campus.

We substantiated that a supervisor removed confidential documents from the West Campus; however, the information had been shredded. The supervisor told us she took bags of shredded paper to her home to use as bedding for her dogs. We found that the documents, duplicate reports of payments made to vendors, were properly destroyed by shredding. We can understand the supervisor assuming she was doing nothing wrong by removing the shredded paper, but under Federal regulations, the paper is considered Government property and must be removed by a contractor or by properly designated in-house personnel. Management informed us they would discuss this issue with the supervisor, therefore, we made no formal recommendation.

Unsubstantiated allegation

We did not substantiate the following allegation regarding the improper disposition of narcotics at the West Campus:

- A complainant alleged that narcotics had not been properly disposed at the West Campus. We reviewed West Campus guidance regarding the disposition of controlled drugs and found they provided adequate instruction. We also reviewed the destruction documents for controlled drugs destroyed between November 1995 and August 1997. Each document was properly stamped and signed. Furthermore, we inspected the pharmacy and found that controlled drugs were stored in a vault. According to the Chief, Pharmacy Service the vault door is always locked. He said the lock uses computer-programmed keys. Each key is usable only during certain times. We were told that there had been no police reports of missing controlled drugs during this period.

Issue 9: Recording Workload Information and Documenting the Supervision Provided to Residents

We did not substantiate the following allegations regarding physicians and nurses at the East Campus:

- A complainant alleged that workload statistics for the Urology Section, Medical Service at the East Campus were purposefully skewed to reflect that a physician performed less work than he actually did, thus creating the illusion that the physician was no longer needed. Workload summary documents indicated that a resident was accomplishing the work in the Urology Section. However, the Urology Section had no resident. According to Information Resources Management Service officials, the report was in error due to a computer programming problem. We were told the problem was corrected.

- A complainant alleged that for several years in the early to mid-1990's residents at the East Campus were performing procedures in the Intensive Care Unit beyond their privileging limits and without supervision by attending physicians from the affiliate, the Morehouse School of Medicine. Whenever a resident performs a procedure he or she is not privileged to do, an attending physician must supervise the resident. We asked nine staff nurses normally assigned to the Intensive Care Unit if they had seen residents perform procedures beyond their privileges without supervision. Eight of the nurses told us they either had not seen a resident in the Intensive Care Unit, or could not recall seeing a resident do anything they believed was inappropriate. One nurse said she believed a resident had performed questionable procedures on one patient, but was unable to provide us the name of the patient so that we could further review the specific circumstances. We also reviewed medical records for 30 patients who were in the Intensive Care Unit during the time period in question. We found no instances in which a resident provided treatment to these patients while they were in the Intensive Care Unit. We did find that a resident was involved in the care of 9 of the 30 patients at some time before or after the patient was in the Intensive Care Unit. The procedures they performed on the 9 patients were either within their scope of privileges or were supervised by an attending physician.

SUMMARY OF RECOMMENDATIONS

Recommendation 1 (Page 12)

The Director, VISN 7, should:

a. Take appropriate administrative action against Mr. Clay for improperly spending funds to renovate his and the Associate Director's quarters, attempting to use appropriated funds for an employee picnic, improperly using his Government credit card, and interfering with an OIG review.

b. Reappraise the Director's and Associate Director's quarters as of the date the renovations discussed above were completed, adjust the rent charged to Mr. Clay and Mr. Hawkins accordingly, and bill them for any retroactive rent due.

c. Ensure that a bill of collection is issued to the Director in the amount of $202.98 to repay VA for the cost of installing a new icemaker in his personal refrigerator.

d. Ensure that Mr. Clay takes appropriate administrative action against ***(b)(6)***, whose behavior towards patients and co-workers was questioned on numerous occasions.

Recommendation 2 (Page 25)

The Director, CAVHCS, should:

a. Issue a bill of collection to Mr. Hawkins for excess meal reimbursements, unnecessary laundry expenses, and for a duplicate claim he received funds for during his permanent change of duty station moves to Saginaw Michigan and CAVHCS (questionable costs totaled $4,388.90).

b. Take appropriate administrative action against Mr. Hawkins for violating the Federal nepotism law [5 U.S.C. § 3110] and committing a prohibited personnel practice [5 U.S.C. § 2302(b)(7)] by advocating his son for employment, making excessive claims on his travel vouchers, and attempting to pressure a subordinate to inappropriately spend appropriated funds for an employee picnic.

c. Issue a bill of collection to Mr. Hawkins' son to recoup salary paid to him during his employment.

d. Instruct Mr. Hawkins to coordinate his purchasing decisions with staff knowledgeable about economic sources of supply before he decides on a purchase strategy.

e. Remind Mr. Hawkins that equipment purchased with appropriated funds may generally not be used for the exclusive benefit of staff.

f. Take appropriate administrative action against Mr. Hawkins for interfering with an OIG review.

Recommendation 3 (Page 31)

The Director, VISN 7 should:

a. Increase VISN's involvement in the conflict between top management and the managers discussed during this review with the objective of ensuring all staff are working effectively together towards VA goals.

b. Ensure that any computer accesses that were denied are not interfering with the job performances of any of the affected managers.

Recommendation 4 (Page 62)

The Director, VISN 7 should:

a. Take appropriate administrative action as to CAVHCS Director Mr. Jimmie Clay's prohibited personnel practices.

b. Take appropriate administrative action as to CAVHCS Associate Director Mr. John Hawkins' prohibited personnel practices.

c. Take appropriate administrative action to correct ***(b)(6)*** s nonselection as CAVHCS ***(b)(6)***.

d. Take appropriate administrative action to correct ***(b)(6)*** nonselection as CAVHCS ***(b)(6)***.

e. Take appropriate administrative action to correct ***(b)(6)*** nonselection as CAVHCS ***(b)(6)***.

f. Take appropriate administrative action to correct ***(b)(6)*** nonselection as CAVHCS ***(b)(6)***.

g. Take appropriate administrative action to correct personnel actions relating to ***(b)(6)*** duties and responsibilities.

Recommendation 5 (Page 77)

The CAVHCS Director, in conjunction with the Director, VISN 7, should:

a. Ensure all regulatory and procedural violations identified by the HRM component of this review are corrected.

b. Assign displaced CAVHCS managers to supportable GS-13 positions within the facility if they qualify for the assignments, and if not, follow Reduction-in-Force procedures to ensure employee rights are protected.

c. Cancel the October 1997 promotions of the three CAVHCS employees occupying the ombudsman positions.

d. If the positions are still warranted, finalize the classification of the GS-9 position description and prepare and classify a GS-7 position description. If candidates for the GS-5 level will be reviewed, classify a position description and develop a crediting plan for the GS-5 level.

e. If a decision is made to fill the positions, start the staffing process over or panel applications received in the previous staffing process and construct new selection certificates based on the panel results. In either case, ensure the actions are in full compliance with Federal regulations and VA and CAVHCS merit promotion requirements.

f. Retroactively adjust the salaries of the three managers as discussed in the report to reflect the correct amount that should be paid to these employees.

g. Initiate overpayment and collection actions and notify the employees of the intention to recoup the inappropriate amounts of salaries paid to them.

h. Ensure all other recent ‘paysetting’ actions were conducted in accordance with appropriate policies and procedures.

i. Seek the assistance of Human Resources professionals outside VISN 7 to work with the CAVHCS HRM staff in implementing the required corrective actions.

j. Ensure the CAVHCS human resources staff receives training in classification, staffing, and paysetting.

Recommendation 6 (Page 85)

The Director, CAVHCS, should:

a. Reduce the waiting time for dermatology consultations.

b. Ensure that physicians examine patients properly and clearly record their plans.

c. Ensure that clinicians completely record assessments and treatments with consideration of patients' rights to informed consent.

d. Ensure that the Chief of Staff follows up a patient's epileptic status and procurement of proper neurological consultation.

e. Ensure that appropriate administrative action is taken for physicians whose care has been found to be deficient.

f. Systematically review patients returning to the outpatient clinic within three days.

Recommendation 7 (Page 89)

The Director, CAVHCS, should require nursing managers to use the data from the VA-prescribed Methodology for Nurse Staffing and Resource Management, and to consider a staffing methodology that is more responsive to changes in patient census and acuity. For example, certain employees might be specifically assigned as temporary "float" nurses to whichever unit requires the most assistance.

Recommendation 8 (page 95)

The Director, CAVHCS, should:

a. Require clinicians to evaluate procedures for appropriate delivery of enteral nutrition, including use of proper tubes, monitoring of residuals, administration of free water, and documentation of amount of formula and water administered.

b. Require the Nutrition Support Team to develop a parenteral nutrition protocol that is consistent with VHA's Chapter on "Specialized Nutritional Support" and current relevant nutritional and medical literature.

c. Form an interdisciplinary team to arrange for the provision of staff training regarding the provision of specialized nutrition support.

d. Require nursing managers to establish, implement, and monitor

compliance with a consistent procedure for obtaining, recording and monitoring patient weights throughout the facility.

e. Require nursing managers to provide adequate quantities and types of scales.

f. Require nursing managers to ensure that knowledgeable employees are available to assist patients who require help with feeding.

Recommendation 9 (Page 98)

The Director, CAVHCS, should take appropriate disciplinary action against employees found to be abusive toward patients.

Recommendation 10 (Page 101)

The Director, CAVHCS, should:

a. Review the appropriateness of the current physician supervisory relationship with the physician assistant in the absence of the Acting Chief, PM&R Service.

b. Require the relief-physician to make rounds regularly, and as needed with the physician assistant, to personally evaluate any patient whose treatment requires his/her co-signature.

c. Ensure the Acting Chief, PM&R Service discusses treatment changes with prescribing physicians before he revises prescriptions.

Recommendation 11 (Page 103)

The Director, CAVHCS, should:

a. Authorize and recruit for additional respiratory therapy employees to accomplish the Cardiopulmonary Section's mission, and establish a cross-training program whereby other properly skilled clinical employees can learn the fundamentals of the section's duties such as electrocardiograms.

b. Facilitate the routine availability of liquid medications on the Nursing Home Care Unit.

Recommendation 12 (Page 106)

The Director, CAVHCS, should limit the number of hours physicians are scheduled to work continuously.

Recommendation 13 (Page 110)

The Director, CAVHCS, should:

a. Assign “code green” evaluation activities to a quality management committee for quarterly assessments.

b. Require responsible employees to properly complete “code green” forms in a timely manner.

c. Instruct nurses to set cardiac monitor alarm volumes at the nurse’s station high enough to be heard.

d. Instruct Intensive Care Unit nurses to set heart rate monitor parameters to an acceptable level for each patient.

e. Explore reasons for possible underreporting of medication errors, and remove disincentives for reporting, where it is possible to do so.

f. Instruct West Campus QM employees to review all medication errors quarterly, and include physicians in the review process.

Recommendation 14 (Page 112)

The Director, CAVHCS, should:

a. Require an interdisciplinary team to conduct facility wide environmental evaluations of cleanliness, pest control, and safety hazards on a recurring basis.

b. Give high priority to work orders for correction of environmental problems at the East Campus.

Recommendation 15 (Page 114)

The Director, CAVHCS, should:

a. Strengthen local Do Not Resuscitate policy by stipulating a standard method of labeling such patients’ medical records.

b. Review and clarify policies and procedures related to Do Not Resuscitate orders and Advance Directives.

c. Provide training to employees in Do Not Resuscitate and Advance Directives procedures, and monitor their appropriate application.

Recommendation 16 (Page 126)

The Director, CAVHCS, should:

a. Take appropriate administrative action against the Chief, ·***(b)(6)***· · · · · Service at the West Campus for misusing Government property and official time to conduct a private business.

b. Ensure that East Campus motor pool employees require all drivers of Government vehicles to complete trip tickets each time they use such vehicles.

c. Ensure that all drivers of Government vehicles possess the appropriate driver's license.

d. Review the amount of inappropriate ·***(b)(6)***· · · · · · · · ·the former Chief, ·***(b)(6)***· · · · · ·Service, East Campus, administered to himself and his family, and issue a bill of collection to the former employee.

Recommendation 17 (Page 129)

The Director, CAVHCS, should:

a. Take appropriate administrative action against those employees discussed above who misused their Government credit card, if such action has not already been taken.

b. Develop a review process whereby inappropriate Government credit card purchases are detected and reported to management.

c. Remind all staff who have been issued Government credit cards that the cards may be used only while they are on official travel, and only for official purposes.

Recommendation 18 (Page 132)

The Director, CAVHCS, should ensure that supervisory Nursing Service staff at the East Campus:

a. Properly approve and certify overtime worked by staff.

b. Monitor sick leave use and implement appropriate corrective measures when sick leave abuse is suspected or found.

Recommendation 19 (Page 135)

The Director, CAVHCS, should ensure that purchasing agents obtain the most economical items, and do not pay extra for unnecessary amenities.

Recommendation 20 (Page 138)

The Director, CAVHCS, should ensure that:

a. All malfunctioning fire doors at the East Campus are repaired, and all fire alarm boxes identified.

b. Bacteriological inspections of the East Campus canteen are performed and documented to ensure sanitary conditions.

Recommendation 21 (Page 141)

The Director, CAVHCS, should take appropriate administrative action against the East Campus nurse who made an anti-Semitic comment.

Recommendation 22 (Page 144)

The Director, CAVHCS, should determine under what circumstances patients and or their caregivers would qualify for extended stays in the Hoptel, and if appropriate change the existing Hoptel policy.

CHIEF NETWORK OFFICER COMMENTS

Department of Veterans Affairs

Memorandum

Date: September 14, 1998

From: Chief Network Officer (10N)

Subj: Response to OIG Report on CAVHCS

To: Inspector General (50)

1. In response to your September 3rd memorandum to me, I have reconsidered my earlier response to the OIG recommendations cited in your memorandum. Upon further review and analysis, I have reconsidered my previous decision and revised several of our responses.

2. However, based on our analysis and input from legal counsel, we feel we cannot concur with recommendations 4a, 4e, 4f, and 4g. I understand that at this point, the unresolved recommendations will be referred to the Secretary for final resolution.

3. Please feel free to contact me should you have any questions.

(Odette Levesque for:)
Kenneth J. Clark

Attachment

VA FORM MAR 1989 **2105**

CHIEF NETWORK OFFICER COMMENTS

SUMMARY OF RECOMMENDATIONS

Recommendation 1

The Director, VISN 7, should:

a. *Take appropriate administrative action against Mr. Clay for 1) improperly spending funds to renovate his and the Associate Director's quarters, 2) attempting to use appropriated funds for an employee picnic, 3) improperly using his Government American Express card, and 4) interfering with an OIG review.*

(Please note that Recommendation 1.a has been broken down into four separate recommendations for ease in responding.)

1. *Take appropriate administrative action against Mr. Clay for improperly spending funds to renovate his and the Associate Director's quarters.*

VHA Response: Concur.

Appropriate action will be proposed

2. *Take appropriate administrative action against Mr. Clay for attempting to use appropriated funds for an employee picnic.*

VHA Response: Concur.

Although the picnic did not take place as planned, that was the case only because the Network was made aware of the attempted use of appropriated funds and ordered the picnic cancelled. Appropriate administrative action will be proposed.

3. *Take appropriate administrative action against Mr. Clay for improperly using his Government American Express Card.*

VHA Response: Concur.

Appropriate administrative action will be proposed. However, we believe this was an innocent mistake on Mr. Clay's part. It should be noted that he voluntarily turned in his government credit card and paid the credit card bill.

4. Take appropriate administrative action against Mr. Clay for interfering with an OIG review.

VHA Response: Concur.

It is not possible to determine Mr. Clay's intentions on this issue. However, regardless of intent, the actions displayed poor judgment. Appropriate administrative action will be proposed.

b. Reappraise the Director's and Associate Director's quarters as of the date the renovations discussed above were completed, adjust the rent charged to Mr. Clay and Mr. Hawkins accordingly, and bill them for any retroactive rent due.

VHA Response: Deferred.

Per recommendation of the OIG, this will be deferred until the OIG Office of Audit report on QMIS is completed.

c. Ensure that a bill of collection is issued to the Director in the amount of $202.98 to repay VA for the cost of installing a new icemaker in his personal refrigerator.

VHA Response: Concur in part.

VHA concurs that the evidence is somewhat contradictory although it does appear that Mr. Clay has changed his story from his original interview. It is our understanding that the OIG is planning to return to CAVHCS to interview the witnesses to determine what actually occurred. VHA will take appropriate action based upon the results of that follow-up investigation.

d. *Ensure that Mr. Clay take appropriate administrative action against* ***(b)(6)*** *; whose behavior towards patients and co-workers was questioned on numerous occasions.*

VHA Response: Concur in part.

VHA concurs that action should have been taken against ***(b)(6)*** prior to the expiration of her settlement agreement. Since this did not occur, no formal disciplinary or adverse action can be taken. However, VHA will ensure that ***(b)(6)*** is reassigned to a position which does not require direct patient contact to reduce the possibility of another altercation. In addition, CAVHCS management will closely monitor her behavior and take swift, decisive action

should another incident occur. One significant process problem at CAVHCS was the lack of adequate case files and tracking systems within Human Resources Management Service. This is being corrected. The HR team being assembled to provide assistance to the CAVHCS HR Service will include an experienced Labor/Employee Relations Specialist who will assist in this effort.

Recommendation 2

The Director, CAVHCS, should:

a. *Issue a bill of collection to Mr. Hawkins for excess meal reimbursements, unnecessary laundry expenses, and for a duplicate claim he received funds for during his permanent change of duty station moves to Saginaw Michigan and CAVHCS (questionable costs totaled $4,392.90).*

VHA Response: Concur in part.

Upon review by Fiscal Service, a bill of collection for $80 was issued to Mr. Hawkins for the overpayment associated with the duplicate reimbursement for TDY travel and Temporary Quarters.

VHA will request that Austin conduct a complete audit of Mr. Hawkins' travel claims and will issue a bill of collection, if appropriate, based upon that audit.

b. Take appropriate administrative action against Mr. Hawkins for 1) violating the Federal nepotism law [5 U.S.C. § 3110] and committing a prohibited personnel practice [5 U.S.C. § 2302(b)(7)] by advocating his son for employment, 2) making excessive claims on his travel vouchers, and 3) attempting to pressure a subordinate to inappropriately spend appropriated funds for an employee picnic.

(Please note that Recommendation 2.b has been broken down into three separate recommendations for ease in responding.)

1. *Take appropriate administrative action against Mr. Hawkins for 1) violating the Federal nepotism law [5 U.S.C. § 3110] and committing a prohibited personnel practice [5 U.S.C. § 2302(b)(7)] by advocating his son for employment.*

VHA Response: Concur.

The VHA Investigation Team believes that Mr. Hawkins exercised poor judgement through his action. However, the Team also concluded that his action was unintentional and constitutes a de minimis technical violation of the statute. Appropriate administrative action will be proposed against Mr. Hawkins.

2. *Take appropriate administrative action against Mr. Hawkins for making excessive claims on his travel vouchers.*

VHA Response: Concur in part.

This issue was addressed in Recommendation 2.a.

Appropriate administrative action will be proposed against Mr. Hawkins for submission of duplicate travel claims.

3. *Take appropriate administrative action against Mr. Hawkins for attempting to pressure a subordinate to inappropriately spend appropriated funds for an employee picnic.*

VHA Response: Concur.

The VHA Investigation Team has concurred with this finding. Appropriate administrative action will be proposed.

c. Issue a bill of collection to Mr. Hawkins' son to recoup salary paid to him during his employment.

VHA Response: Concur.

There is no evidence of wrong doing on the part of Mr. Hawkins' son, ***(b)(6)***, in being paid for work as a ***(b)(6)***. However, we agree that a finding of nepotism in OIG recommendation 2b requires that a bill of collection be issued.

d. *Instruct Mr. Hawkins to coordinate his purchasing decisions with staff knowledgeable about economic sources of supply before he decides on a purchase strategy.*

VHA Response: Not Concur.

Without reservation, VHA agrees that it is good management practice to coordinate purchasing decisions with staff knowledgeable of economical sources of supply. In the case of the safety shoes, Mr. Hawkins erred on the side of employee safety and comfort rather than cost. It also appears that he relied on the involved service chiefs to coordinate the acquisition of the shoes. The OIG cites two other instances to support their contention that Mr. Hawkins fails to seek advice on acquisition issues. We feel Mr. Hawkins is aware of the process of requesting service chief input, however we are also aware that there may be

instances when he does not follow the advice received. It is important that every VA management official be afforded the flexibility to use his/her independent judgement when it comes to seeking and using advice from service chiefs. Mr. Hawkins' judgment in the instance of the shoe purchase will be weighed along with other instances, including the employee picnic and contracting with an 8A contractor, when deciding what appropriate administrative action is to be proposed.

e. Remind Mr. Hawkins that equipment purchased with appropriated funds may generally not be used for the exclusive benefit of staff.

VHA Response: Concur.

However, it should be noted that there may be instances whereby the workplace can be equipped with a refrigerator, purchased with appropriated funds, provided that it is reasonably related to the efficient performance of the agency activities and not just for the personal convenience of individual employees.

f. Take appropriate administrative action against Mr. Hawkins for interfering with an OIG review.

VHA Response: Concur.

The VHA Investigation Team has concurred with this finding. Appropriate administrative action will be proposed.

Recommendation 3

The Director, VISN 7 should:

a. *Increase VISNs involvement in the conflict between top management and the managers discussed during this review with the objective of ensuring all staff are working effectively together towards VA goals.*

VHA Response: Concur.

The changes occurring throughout VHA, occurring within VISN 7, and resulting from the process of integrating the Montgomery and Tuskegee medical centers have caused anxiety to all levels of employees and other stakeholders. Regardless of what actions are taken everyone will not buy-in to different organizations or different leadership. The VISN realizes that both the integration and the OIG investigation have resulted in polarization of some groups from others. It is not our intent to imply that the OIG caused the problems at CAVHCS, but rather that the audit and the activities that took place subsequent to the audit have contributed to the polarization of some groups. An example of this can be found in articles appearing in the Montgomery Advertiser (newspaper). However, since the beginning of the integration process the VISN Director, Clinical Manager, and other VISN staff have spent an extraordinary amount of time facilitating groups, attending town hall meetings, and working side by side with local staff members. Further, the VISN has supported local staff with outside consultants, VISN experts, and team building training. When observed objectively, these efforts have been successful regarding the vast majority of stakeholders involved in both the integration and the OIG investigation. To increase the chances of all staff working together, the VISN assigned a new Acting Medical Center Director and Acting Associate Medical Center Director who have held a series of meetings to help build bridges among employees. The VISN staff will continue to lend support to CAVHCS as it transitions through the changes that will be brought about by both the integration and the OIG investigation.

b. *Ensure that any computer accesses that were denied are not interfering with the job performances of any of the affected managers.*

VHA Response: Concur.

When the new service managers were selected and reported for duty, the existing service chiefs no longer required the complete access necessary for their former responsibilities. As they undertook new job responsibilities, they were provided access appropriate to these work assignments.

Recommendation 4

The Director, VISN 7 should:

a. *Take appropriate administrative action as to CAVHCS Director Mr. Jimmie Clay's prohibited personnel practices.*

VHA Response: Not Concur.

Mr. Clay's lack of knowledge and failure to be actively involved in the selection of key medical center managers represents performance below that which would be expected of VHA senior managers. A medical center director would normally be expected to follow closely the process of selection and, if not actively involved, at least be familiar with the candidates and the process of selection. However, there is a problematic evidentiary question as to the level of Mr. Clay's involvement in the actual selection and selection process, and thus whether his action rises to the level anticipated by 5 U.S.C. 2302(b). Mr. Clay delegated the selection of the service chiefs to Mr. Hawkins and by all appearances deferred to Mr. Hawkins' decision in making those selections. We find nothing evidencing that Mr. Clay reviewed the applications or was otherwise aware of the comparative qualifications of the candidates. There is also a dearth of evidence that his approval was more than a mere concurrence in the selections made by Mr. Hawkins or that his action was based on reasons other than those cited in Mr. Hawkins' selection memorandum. It is anticipated that this insulation from the actual selection process and decision would be asserted in defense of any related disciplinary action against him. Although there is room for debate, weighing this factor as a trial consideration, it is concluded that such a defense could seriously jeopardize the agency's ability to support a disciplinary action based on prohibited personnel practice for non-selection.

Although OIG indicates disclosures/cooperation and knowledge at or about the time of the service chiefs' selections, discussion in support of the recommendation does not include dates or relative time frames which support that conclusion. For example, several statements by Mr. Clay, which were relied upon to evidence his knowledge of certain disclosures, were made in interviews several months after the selections. Such statements, therefore, do not conclusively show that he had such knowledge at the time he concurred in Mr. Hawkins' selections. Without specific facts showing the requisite time frames, it is not possible to properly evaluate whether the disclosures and/or cooperation, and Mr. Clay's knowledge, predated any approval action and could, therefore, serve as an evidentiary basis for a retaliatory motive.

Additionally, for some of the non-selectees, there is insufficient evidence of any disclosure or cooperation with OIG or of Mr. Clay's knowledge of same. For example, it is conceded by OIG that ***(b)(6)*** has not claimed to have

made any complaints to OIG or to Congressman Everett. It is stated that he cooperated with OIG, but such cooperation alone is not sufficient to evidence the requisite disclosure or cooperation or to indicate a motive for retaliation. Numerous employees, including selectees ***(b)(6)*** and ***(b)(6)***, cooperated with and were interviewed by OIG. It further appears that ***(b)(6)*** was interviewed by OIG only a few days prior to the time Mr. Clay signed off on the selection. Moreover, there is no indication that at the time of the selection either Mr. Clay or Mr. Hawkins was personally aware that ***(b)(6)*** was being interviewed or of what information he might be providing to OIG.

Unless it can be shown that Mr. Clay was aware of the noted irregularities in the screening panel's scoring, the fact that ***(b)(6)*** did not rank among the top three candidates appears to be a legitimate basis for his non-selection. Not being one of the top three, the significant factor test would not be met because it is unlikely that Mr. Clay would have had any reason to override the recommendation of the screening panel and Mr. Hawkins' selection in favor of ***(b)(6)***.

There is also neither direct nor sufficient circumstantial evidence that Mr. Clay had knowledge of any disclosures made by ***(b)(6)*** or that his cooperation with the OIG investigation was in any way different from that of numerous other CAVHCS employees who cooperated by responding to OIG inquiries. There is also some indication that ***(b)(6)*** may not have been interviewed by OIG until more than two months after his non-selection for the Chief, ***(b)(6)*** position. The only other evidence presented is ***(b)(6)***'s knowledge of ***(b)(6)*** cooperation with OIG in a criminal investigation. There is no indication that ***(b)(6)*** communicated this information to Mr. Clay or that it could otherwise be imputed to him.

Based on our review, VHA concludes that Mr. Clay did not involve himself in the selection of these key management officials in any meaningful way. In delegating the selection to Mr. Hawkins and relying on his input almost exclusively, he served to inappropriately insulate himself from the selection process. While VHA does not believe that the facts meet the requirements of a prohibited personnel practice on the part of Mr. Clay, we do conclude that it constitutes poor management for which appropriate administrative action will be taken.

b. Take appropriate administrative action as to CAVHCS Associate Director Mr. John Hawkins' prohibited personnel practices.

VHA Response: Concur.

The VHA Investigation Team has recommended that supportable evidence exists for several of the allegations in the OIG report. Once their investigation of the evidence and follow-up interviews is completed, appropriate action will be proposed.

c. Take appropriate administrative action to correct ***(b)(6)*** *non-selection as CAVHCS* ***(b)(6)***

VHA Response: Concur.

The VHA Investigation Team has concluded that Mr. Hawkins exhibited evidence of animus towards ***(b)(6)*** in the selection process. Action will be taken to place ***(b)(6)*** in an appropriate position to settle both this complaint and his EEO complaint.

d. Take appropriate administrative action to correct ***(b)(6)*** *non-selection as CAVHCS* ***(b)(6)***

VHA Response: Concur.

The VHA Investigation Team has concluded that Mr. Hawkins exhibited evidence of animus towards ***(b)(6)*** in the selection process. Since he has accepted a transfer to the ***(b)(6)*** VAMC, appropriate efforts will be made to settle this case and his EEO complaint.

Preamble to 4e to 4g

For several of the employees identified by OIG, the evidence is insufficient to insure that the agency could meet its burden of proof in any appeal of a disciplinary action based on alleged prohibited personnel practice under 5 U.S.C. 2302(b)(8) or 2302(b)(9). To meet its burden the agency must prove by a preponderance of the evidence that: (1) the acting official (Clay/Hawkins) has the authority to take, recommend, or approve any personnel action; (2) the aggrieved employee made a disclosure protected under section 2302(b)(8) or cooperated with OIG pursuant to section 2302(b)(9); (3) the acting official used his authority to take, or refuse to take, a personnel action against the aggrieved employee; and (4) the acting official took, or failed to take, the personnel action against the aggrieved employee because of the protected disclosure. Inherent in this last element is the requirement that the acting official have knowledge of the disclosure. The difficulties of proving the alleged incidents of prohibited personnel practice primarily involve the nature and specificity of the disclosure or cooperation with OIG; the knowledge of any such disclosure by Mr. Hawkins or

Mr. Clay; and whether that knowledge was a significant factor in the personnel action in question. A "significant factor" is one based on improper motive and one that plays an important role in the alleged retaliatory action. If an appellant shows that he would have taken the personnel action absent the protected disclosure, the "significant factor" test is not met. *Gores v. Department of Veterarns Affairs*, 68 M.S.P.R. 100, 114 (1995).

e. *Take appropriate administrative action to correct* ***(b)(6)*** *non-selection as CAVHCS* ***(b)(6)***.

VHA Response: Not Concur.

Unless it can be shown that ***(b)(6)*** non-selection was the result of a violation of 5 U.S.C. 2302(b)(8) or 2302(b)(9), there is no basis for taking corrective action. As outlined in the response to Recommendation 4 a., evidence of the knowledge and time elements necessary to substantiate such a violation have not been established.

f. *Take appropriate administrative action to correct* ***(b)(6)*** *non-selection as CAVHCS* ***(b)(6)***.

VHA Response: Not Concur.

Unless it can be shown that ***(b)(6)*** non-selection resulted from a violation of 5 U.S.C. 2302(b)(8) or 2302(b)(9), there is no basis for taking the proposed administrative action. As outlined in the response to Recommendation 4 a., evidence sufficient to prove such a violation has not been established.

g. *Take appropriate administrative action to correct personnel actions relating to* ***(b)(6)*** *duties and responsibilities.*

VHA Response: Not Concur.

The VHA Investigative Team did not find the requisite improper motive arising from allegations which ***(b)(6)*** brought to the CAVHCS management concerning ***(b)(6)*** or from his cooperation in the ensuing OIG investigation of those allegations. It is further noted that there is an absence of definitive time frames to support an assumption of retaliatory motive related to these or other alleged disclosures.

As evidence of a retaliatory motive, it is stated that the changes in ***(b)(6)*** duties contravened instructions from VISN not to take action affecting any of the

employees who had complained to the OIG about the selection process. It is reasonable to assume that such instructions applied only to those displaced chiefs who had complained of their non-selections. ***(b)(6)*** was not included in that group and no evidence is cited to show how he would come within the scope of those instructions.

In defense of an allegation of retaliatory motive, the facts provide some rationale basis for the consolidation of the services and for the selection of ***(b)(6)*** as the chief of the combined service. There is evidence that the consolidation of these services had been under consideration for some length of time and that Mr. Clay had directed a special study to look at consolidating the two services. He also articulated several performance-based problems with ***(b)(6)*** and that the effectiveness of the ***(b)(6)*** Services had been hampered by the lack of an effective relationship between ***(b)(6)*** and the former chief of ***(b)(6)*** Service, ***(b)(6)***. Furthermore, there seems to be a legitimate basis for filling the ***(b)(6)*** chief's position with ***(b)(6)***, who was a displaced GS-13 supervisor, as opposed to ***(b)(6)*** ; a GS-12.

For the foregoing reasons, it is concluded that there is insufficient evidence of a prohibited personnel practice with regard to ***(b)(6)***. Without such evidence there is no justification for taking corrective actions related to his duties and responsibilities.

Recommendation 5

The CAVHCS Director, in conjunction with the Director, VISN 7, should:

a. *Ensure all regulatory and procedural violations identified by the HRM component of this review are corrected.*

VHA Response: Concur.

The Human Resources Manager at CAVHCS will correct these violations. In addition, the Network Director has requested that the Office of Personnel Management conduct a personnel management evaluation, which has already been completed.

b. *Assign displaced CAVHCS managers to supportable GS-13 positions within the facility if they qualify for the assignments, and if not, follow Reduction-in-Force procedures to ensure employee rights are protected.*

VHA Response: Concur.

CAVHCS, with the assistance of Human Resources Management Service, is drafting appropriate position descriptions. If supportable positions cannot be developed, CAVHCS will follow applicable Reduction-in-Force procedures to place these employees.

c. Cancel the October 1997 promotions of the three CAVHCS employees occupying the ombudsman positions.

VHA Response: Concur.

The technical errors in the Merit Promotion Process require correction. CAVHCS will convene a panel to review the applications received during the previous staffing process and construct new selection certificates based upon the panel results. The Acting Director, CAVHCS, will submit a report on the findings by October 1, 1998. Based on the outcome of this report, appropriate action will be taken to correct any erroneous promotions/selections.

d. *If the positions are still warranted, finalize the classification of the GS-9 position description and prepare and classify a GS-7 position description. If candidates for the GS-5 level will be reviewed, classify a position description and develop a crediting plan for the GS-5 level.*

VHA Response: Concur.

CAVHCS has developed and classified new position descriptions.

e. If a decision is made to fill the positions, start the staffing process over or panel applications received in the previous staffing process and construct new selection certificates based on the panel results. In either case, ensure the actions are in full compliance with Federal regulations and VA and CAVHCS merit promotion requirements.

VHA Response: Concur.

CAVHCS will convene a panel to review the applications received during the previous staffing process and construct new selection certificates based upon the panel results. The Acting Director, CAVHCS, will submit a report on the findings by October 1, 1998.

f. *Retroactively adjust the salaries of the three managers as discussed in the report to reflect the correct amount that should be paid to these employees.*

VHA Response: Concur.

CAVHCS has corrected the incorrect pay actions. Attached are the corrected Standard Forms 50-B entitled “Notification of Personnel Action” for each requested action.

g. *Initiate overpayment and collection actions and notify the employees of the intention to recoup the inappropriate amounts of salaries paid to them.*

VHA Response: Concur.

Attached are the bills of collection issued by CAVHCS.

h. Ensure all other recent "paysetting" actions were conducted in accordance with appropriate policies and procedures.

VHA Response: Concur.

CAVHCS will conduct an internal review of paysetting practices. In addition, the OPM audit scheduled for August, 1998 will review paysetting.

i. Seek the assistance of Human Resources professionals outside VISN 7 to work with the CAVHCS HRM staff in implementing the required corrective actions.

VHA Response: Concur.

The Network has requested an internal review of Human Resources by the Office of Personnel Management (OPM) to provide a baseline and suggestions for improvement. (The review is scheduled for August, 1998.) This outside review by OPM will permit the Acting Medical Center Director, CAVHCS, and the Human Resources Manager an unbiased assessment by the HR regulatory body. Foci of the OPM review will include merit staffing, classification, incentive awards, and paysetting.

j. *Ensure the CAVHCS human resources staff receives training in classification, staffing, and paysetting.*

VHA Response: Concur.

This has already been identified as a problem and appropriate training plans have been initiated for all Human Resource Management Service employees. The OPM audit team will review the training plans during their review and provide suggestions for improvement to the Human Resources Manager and the Acting Medical Center Director, CAVHCS. Attached is the report entitled “Completed and Anticipated Training for Human Resources Management Service Employees”.

Recommendation 6

The Director, CAVHCS, should:

a. Reduce the waiting time for dermatology consultations.

VHA Response: Concur.

(b)(3) . . . . . CAVHCS will reduce the waiting time for the dermatology clinic. Recruitment of dermatology support has begun. The medical center will monitor results of dermatology consultation waiting time for the periods ending September 30, 1998 and June 30, 1999 and submit the results to the OIG within 60 days of completion.

b. *Ensure that physicians examine patients properly and clearly record their plans.*

VHA Response: Concur.

Review of the current patient assessment and documentation process has been completed. Several recommendations have been initiated to ensure quality care is provided and appropriate monitoring is in place. Attached is the Strategic Quality Plan for Primary Care and information from the Strategic Quality Planning Workshop, which includes a list of developed clinical pathways. The medical center will monitor the results of the Primary Care Process Group and Performance Improvement Team in the Primary Care Process Line for the periods ending September 30, 1998 and June 30, 1999 and will submit the results to the OIG within 60 days of completion.

c. Ensure that clinicians completely record assessments and treatments with consideration of patients' rights to informed consent.

VHA Response: Concur.

Attached is the new Medical Center Memorandum #11-98-31 entitled “Informed Consent” and a memorandum from the Ethics Advisory Committee identifying the plans to provide training on these issues. Chart review monitoring results for the periods ending September 30, 1998 and June 30, 1999 will be submitted to the OIG within 60 days of completion.

d. Ensure that the Chief of Staff follows up a patient's epileptic status and procurement of proper neurological consultation.

VHA Response: Concur.

(b)(3) . . . . . Recruitment has been initiated to obtain an additional neurologist. The Medical Director will track this veteran to ensure he receives the appropriate care.

e. Ensure that appropriate administrative action is taken for physicians whose care has been found to be deficient.

VHA Response: Concur, with a clarification.

It is important to clarify the difference between the need for disciplinary action due to inappropriate care versus providing feedback when a treatment plan is appropriate, but not effective. Attached are the Bylaws of the Medical Staff, approved in November 1997, which outline disciplinary procedures when deficiencies are identified.

f. Systematically review patients returning to the outpatient clinic within three days.

VHA Response: Concur.

This issue has been referred to the Network Quality Management Officer for further review and recommendations. Concurrently, the medical center will monitor the results of patients returning to the outpatient clinic within three days for unscheduled appointments for the periods ending September 30, 1998 and June 30, 1999. The results of the monitoring will be submitted to the OIG within 60 days of completion.

Recommendation 7

The Director, CAVHCS, should require nursing managers to use the data from the VA-prescribed Methodology for Nurse Staffing and Resource Management, and to consider a staffing methodology that is more responsive to changes in patient census and acuity. For example, certain employees might be specifically assigned as temporary "float" nurses to whichever unit requires the most assistance.

VHA Response: Partially Concur.

Staffing levels have been reviewed throughout the medical center to ensure adequate nursing care is available. The medical center nurse staffing policy has been reviewed to ensure a methodology is in place to allow the shifting of nursing staff to meet the nursing care requirements throughout the medical center. The VA Methodology for Nurse Staffing and Resource Management does not reflect the flexibility required to manage an integrated healthcare system. Attached is a memorandum addressing staffing levels, which is a summary of changes made to improve availability of adequate nursing staff, and a Nursing Service Policy #A-02 entitled "Staffing Methodology".

Recommendation 8

The Director, CAVHCS, should:

a. Require clinicians to evaluate procedures for appropriate delivery of enteral nutrition, including use of proper tubes, monitoring of residuals, administration of free water, and documentation of amount of formula and water administered.

VHA Response: Concur.

Relevant policies have been reviewed and updated as necessary. Ross Quantum Pumps have been procured which will allow the practitioners better quantifiable information to assist in the monitoring process. Attached is the following:

1. Criteria used for specific types of naso-gastric feeding tubes
2. Medical Center Memorandum #001A-98-03 entitled "Administration of Enteral Nutrition"
3. Medical Center Memorandum #001A-98-01 entitled "Food Service to Patients"
4. Medical Center Memorandum #001A-98-2 entitled "Oral Nutritional Supplements"
5. Medical Center Memorandum #001A-98-04 entitled "Diet Prescription"
6. Medical Center Memorandum #001A-98-05 entitled "Scope of Practice for Clinical Dietitians"
7. Medical Center Memorandum #001A98-06 entitled "Food Provided to Inpatients from Other Sources"
8. Performance Improvement Plan for Nutrition and Food Service for FY1998/99

Monitoring results of adherence to the tube feeding policy, including assessment of patients' free water requirements, for the periods ending September 30, 1998 and June 30, 1999 will be submitted to the OIG within 60 days of completion.

b. *Require the Nutrition Support Team to develop a parenteral nutrition protocol that is consistent with VHA's Chapter on "Specialized Nutritional Support" and current relevant nutritional and medical literature.*

VHA Response: Concur.

Attached is the Parenteral Nutrition Order Form developed by the medical center's Nutrition Committee and a Nutrition and Food Service Policy Memorandum #C-1 entitled "Nutritional Screening, Evaluation and Assessment of Hospitalized Patients".

c. Form an interdisciplinary team to arrange for the provision of staff training regarding the provision of specialized nutrition support.

VHA Response: Concur.

Attached is Medical Center Memorandum #001A-98-100 entitled "Nutrition Committee", many minutes from the Nutrition Committee addressing nutritional support and a memorandum for the record providing training information.

d. *Require nursing managers to establish, implement, and monitor compliance with a consistent procedure for obtaining, recording and monitoring patient weight throughout the facility.*

VHA Response: Concur.

The medical center will monitor weight-measure compliance for the periods ending September 30, 1998 and June 30, 1999 and will submit them to the OIG within 60 days of completion.

e. *Require nursing managers to provide adequate quantities and types of scales.*

VHA Response: Concur.

Nursing conducted an inventory of scales throughout the medical center. A review was completed to determine the best locations throughout the medical center of the different types of scales as dictated by the patient population. Results of this review are attached along with acquisition recommendations.

f. Require nursing managers to ensure that knowledgeable employees are available to assist patients who require help with feeding.

VHA Response: Partially Concur.

It is important to note that the OIG report does not cite any cases where veterans had not been fed. However, the Network recognized this is a concern of all parties. The eating requirements of all patients will be determined and appropriate steps taken to ensure timely eating of meals. An interdisciplinary monitor will be developed to evaluate the success of the improvement plan for feeding patients who require assistance. The monitor will look at the periods ending September 30, 1998 and June 30, 1999. Results will be submitted to the OIG within 60 days of completion.

Recommendation 9

The Director, CAVHCS, should take appropriate disciplinary action against employees found to be abusive toward patients.

VHA Response: Concur.

Abuse of patients is considered a very serious violation. The Acting Medical Center Director, CAVHCS, will ensure that appropriate disciplinary/adverse action will be taken against any employee proven to be abusive toward patients. Cases mentioned in the OIG report will be reviewed to determine whether this, in fact, was done. Results of this review will be forwarded to the OIG within 60 days of completion.

Recommendation 10

The Director, CAVHCS, should:

a. Review the appropriateness of the current physician supervisory relationship with the physician assistant in the absence of the Acting Chief, PM&R Service.

VHA Response: Concur.

Mandatory physician and physician assistant supervisory relationships are currently in place in Physical Medicine and Rehabilitation Service as well as throughout the medical center. Staffing changes have occurred which resolve the concern of professional oversight.

b. Require the relief-physician to make rounds regularly, and as needed with the physician assistant, to personally evaluate any patient whose treatment requires his/her co-signature.

VHA Response: Concur.

Currently, all physicians who provide relief coverage are responsible to ensure a proper treatment program is in place.

c. Ensure the Acting Chief, PM&R Service discusses treatment changes with prescribing physicians before he revises prescriptions.

VHA Response: Concur.

Attached is a statement from the Medical Director, addressed to all members of the medical staff, identifying the requirements to communicate concerns in the treatment plan with the prescribing physicians in order that any discrepancies in the care plan can be resolved.

Recommendation 11

The Director, CAVHCS, should:

a. Authorize and recruit for additional respiratory therapy employees to accomplish the Cardiopulmonary Section's mission, and establish a cross-training program whereby other properly skilled clinical employees can learn the fundamentals of the section's duties such as electrocardiograms.

VHA Response: Concur.

(b)(3) CAVHCS has implemented 24-hour respiratory care coverage and developed training requirements for cross-training staff. Attached is the current list of the Respiratory Therapists, the training plan and a copy of the functional description for a Certified Respiratory Therapy Technician.

b. Facilitate the routine availability of liquid medications on the Nursing Home Care Unit.

VHA Response: Concur.

(b)(3) Liquid medications ordered by a physician will be available to all areas of the medical center. Attached is Medical Center Memorandum #119-98-15 entitled “Pharmacy Service Operations and Procedures” which addresses how to obtain compound medications that are not ordinarily available on the VHA national formulary.

Recommendation 12

The Director, CAVHCS, should limit the number of hours physicians are scheduled to work continuously.

VHA Response: Concur.

Physician work schedule policy will conform to VA published standards. Attached is Medical Center Memorandum #11-98-32 entitled “Medical Officer of the Day” which addresses physicians’ work hours.

Recommendation 13

The Director, CAVHCS, should:

a. Assign "code green" evaluation activities to a quality management committee for quarterly assessments.

b. Require responsible employees to properly complete "code green" forms in a timely manner.

VHA Response to a and b: Concur.

(b)(3) . . . . . and action has been initiated. Attached is a memorandum from the office of the Medical Director for Clinical Programs noting that the Quality Leadership Council has referred monitoring of this issue to the Mental Health and Behavioral Medicine Council. Also attached are the minutes from the Mental Health and Behavioral Medicine Council that discuss the evaluation of "code green". The quarterly findings for the periods ending September 30, 1998 and June 30, 1999 will be submitted to the OIG within 60 days of completion.

c. Instruct nurses to set cardiac monitor alarm volumes at the nurse's station high enough to be heard.

d. Instruct Intensive Care Unit nurses to set heart rate monitor parameters to an acceptable level for each patient.

VHA Response to c and d: Concur.

Parameters to be established by clinical requirements.

e. Explore reasons for possible under-reporting of medication errors, and remove disincentives for reporting, where it is possible to do so.

f. Instruct West Campus QM employees to review all medication errors quarterly, and include physicians in the review process.

VHA Response to e and f. Concur.

The Medical Director for Clinical Programs will continue to encourage the staff to report errors to ensure the best care is provided for the veterans. The Pharmacy, Therapeutic, and Antibiotic Committee of the Medical Staff will track medication

errors by aggregating incidents biweekly and reporting, at least quarterly, the findings to the Medical Director for Clinical Programs. The medical center will submit to the OIG the results of the quarterly medication error review for the periods ending September 30, 1998 and June 30, 1999 within 60 days of completion.

Recommendation 14

The Director, CAVHCS, should:

a. Require an interdisciplinary team to conduct facility wide environmental evaluations of cleanliness, pest control, and safety hazards on a recurring basis.

b. Give high priority to work orders for correction of environmental problems at the East Campus.

VHA Response to a: Concur.

(b)(3) An interdisciplinary team has been established that performs cleanliness, pest control and safety hazard evaluations. The Acting Medical Center Director will ensure that this is done on a recurring basis.

VHA Response to b: Concur, with clarification.

CAVHCS will give high priority to environmental problems at both campuses (not just the East Campus).

Recommendation 15

The Director, CAVHCS, should:

a. Strengthen local Do Not Resuscitate policy by stipulating a standard method of labeling such patients' medical records.

b. Review and clarify policies and procedures related to Do Not Resuscitate orders and Advance Directives.

c. Provide training to employees in Do Not Resuscitate and Advance Directives procedures, and monitor their appropriate application.

VHA Response to a, b and c: Concur.

(b)(3) . . . . . CAVHCS has implemented a corrective action plan. Attached are the Medical Center Memorandum #11-98-17 entitled "Withholding or Withdrawal of Life-Sustaining Treatment", Medical Center Memorandum #11-98-18 entitled "Determination of Brain Death", Medical Center Memorandum #114-97-01 entitled "End of Life Care" and a memorandum from the Ethics Advisory Committee identifying the plans to provide training on these issues. The medical center will monitor the results of these new procedures and will submit to the OIG the results for the periods ending September 30, 1998 and June 30, 1999 within 60 days of completion.

Recommendation 16

The Director, CAVHCS, should:

*a. Take appropriate administrative action against the Chief, ·**(b)(6)**· · · · · Service at the West Campus for misusing Government property and official time to conduct a private business.*

VHA Response: Concur.

Although CAVHCS has taken non-disciplinary action, the Acting Medical Center Director, CAVHCS, requested a complete review of this situation to ensure appropriateness of penalty. His conclusion is that the penalty was appropriate in this situation.

b. *Ensure that East Campus motor pool employees require all drivers of Government vehicles to complete trip tickets each time they use such vehicles.*

VHA Response: Concur.

Attached is the updated CAVHCS Medical Center Memorandum #138A-98-05 entitled "Use of Government Vehicles".

c. *Ensure that all drivers of Government vehicles possess the appropriate driver's license.*

VHA Response: Concur.

Attached is the updated CAVHCS Medical Center Memorandum #138A-98-05 entitled "Use of Government Vehicles".

*d. Review the amount of inappropriate ·**(b)(6)**· · · · · · · · ·the former Chief, ·**(b)(6)**· · · · · ·Service, East Campus, administered to himself and his family, and issue a bill of collection to the former employee.*

VHA Response: Concur.

The Acting Medical Center Director has reviewed this and has issued the attached bill of collection.

Recommendation 17

The Director, CAVHCS, should:

a. *Take appropriate administrative action against those employees discussed above who misused their Government American Express card, if such action has not already been taken.*

VHA Response: Concur.

The Acting Medical Center Director, CAVHCS, will review all local procedures to ensure that individuals provided such cards in the future are trained to use the cards only for government-sponsored travel purposes. Appropriate action has been taken toward the individuals identified in the report.

b. *Develop a review process whereby inappropriate Government American Express card purchases are detected and reported to management.*

VHA Response: Concur.

CAVHCS has implemented a tracking mechanism to detect and report to management any inappropriate government credit card transactions.

c. *Remind all staff who have been issued Government American Express cards that the cards may be used only while they are on official travel, and only for official purposes.*

VHA Response: Concur.

Attached is Medical Center Memorandum #04-98-12 entitled “Employee Travel using the Federal Government Credit Card Program”.

Recommendation 18

The Director, CAVHCS, should ensure that supervisory Nursing Service staff at the East Campus:

a. *Properly approve and certify overtime worked by staff.*

VHA Response: Concur.

Attached is Nursing Service Memorandum A-5 entitled "Overtime" and Nursing Service Memorandum A-13 entitled "Time Planning".

b. *Monitor sick leave use and implement appropriate corrective measures when sick leave abuse is suspected or found.*

VHA Response: Concur.

Attached is Nursing Service Bulletin 98-5 entitled "Guidelines for Medical Certification for Sick Leave Abuse" and Nursing Service Bulletin 98-6 entitled "Guidelines for Tardiness".

Recommendation 19

The Director, CAVHCS, should ensure that purchasing agents obtain the most economical items, and do not pay extra for unnecessary amenities.

VHA Response: Concur.

CAVHCS indicates that the current manager of Logistics Management Service has implemented policies and procedures to ensure appropriate purchasing practice for all purchases. Attached is Medical Center Memorandum #04-98-04 entitled "Government-Wide Purchase Card".

Recommendation 20

The Director, CAVHCS, should ensure that:

a. All malfunctioning fire doors at the East Campus are repaired, and all fire alarm boxes identified.

VHA Response: Concur.

A two-phase construction program has started which will upgrade the fire alarm system at the East Campus. Phase 1 involves the preparation of detailed computerized drawings of the buildings, including verification of the location of the fire alarm and sprinkler system devices. Phase 1 is scheduled for completion in December, 1998. Phase 2 of the construction program is currently in the design phase. Phase 2 will address replacing much of the existing fire alarm system with "state of the art" equipment. Identified documentation deficiencies are being corrected.

b. Bacteriological inspections of the East Campus canteen are performed and documented to ensure sanitary conditions.

VHA Response: Concur.

Bacteriological inspections will be completed at the Canteens on both campuses on a quarterly basis.

Recommendation 21

The Director, CAVHCS, should take appropriate administrative action against the East Campus nurse who made an anti-Semitic comment.

VHA Response: Concur.

The nurse described has retired from CAVHCS effective ***(b)(6)***. No further action will be taken.

Recommendation 22

The Director, CAVHCS, should determine under what circumstances patients and or their caregivers would qualify for extended stays in the Hoptel, and if appropriate change the existing Hoptel policy.

VHA Response: Concur.

The OIG has made a reasonable patient-centered recommendation which has been implemented. Attached is the update Medical Center Memorandum #001C-98-05, entitled “Hoptel/Temporary Lodging Unit”.

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