November 30, 2009

Re: OSC File No DI-08-2379

To: President Obama
Eric Shinseki, Secretary, Dept of Veterans Affairs
Congressional Oversight Committee for Veterans Affairs
Olare Ayeni, Attorney, Disclosure Unit
Siobhan M. Smith, OSC Attorney Case MA-08-2004

Thank you for the extension of time to respond to the report from OMI investigations of the disclosure of abuses to patients and staff to the Office of Special Counsel.

I am shocked and concerned about the lack of professionalism in the process of this so-called one-sided investigation. The two investigations I am involved in have led me to believe that this system of protecting federal whistleblowers is a sham and is not following the letter of the law.

What kind of country do we have where there are laws enacted to protect federal employees to stand up for what is right, against wrongdoing, and those laws are ignored year after year and federal management is supported in crushing the federal employee?

I realize this letter is meant to be a response to the Disclosure Report of Findings, but I find it necessary to speak to both cases, as they are interrelated and cannot be considered in isolation of each other. So therefore, I will comment on some specifics of both cases to demonstrate the tragedy and failure of the system, causing harm to our nations' veterans and the staff that serve them with dignity.

Upon being terminated on falsified charges by VA management, I filed a whistleblower claim with the OSC for Prohibitive Personnel Practice at the suggestion of a human resources manager acknowledging the problems at the Prescott VA, but unable to take any action of meaning. I provided documentation to back up my assertions relative to the charges, and asserted that my employment was terminated as a result of ongoing reporting/disclosing abuses to patients and staff. The attorney at the OSC for the whistleblower division must have felt I had the proof/documentation of what I claimed and asked me to file a case of disclosure because of the overwhelming evidence I had documenting patient abuse. In this long and tedious process, both investigations occurred without the people that are responsible for making the final determinations interviewing me or any witness that can substantiate my claims. The PPP investigation seems to have received testimony from the VA via telephone interview. I don't know what happened to the documentation I presented, as both reports reflect a lack thereof. Dates of specific events have been incorrectly investigated. The investigators would not have found for the VA in both cases, had anyone taken the time to read the specifics of a patient's chart correctly and interview all the witnesses, staff and veterans about the ongoing and increasingly abusive nature of management in their efforts to cover-up complaints.

I was informed by the attorney making the decision for the PPP claim, that the VA management was attempting to fire me prior to my letter to the nurse exec on April 6th, and she knew that I was to be terminated on April 8th. Therefore the attorney making the decision for my PPP case, found my letter, although whistleblower in content, not relevant because the VA were planning on my termination prior to this letter, or so they say now. This attorney did not take into consideration any other information, documentation or proof that demonstrates that if they were in fact trying to fire me prior to my letter, then they were trying to fire me because of reports of abuse, and did so through making up false claims to support their effort to terminate my employment. If this attorney had followed through with his job and interviewed all the other witnesses that were also the brunt of a VA management witch hunt to remove anyone that spoke up against their abusive ways.

The following is that final whistleblower letter via email that I sent to the Nurse exec, on Sunday night at the end of my shift, and might I say, at the request of the night supervisor! Monday I was off duty. Tuesday I was met by my former supervisor and the VA POLICE, terminated and escorted off the VA property. This letter gives an example of my attempts to disclose to management that abuses of patients and staff were taking place and ongoing.

Apr 6, 2008

I want you to know why I am writing this letter to you, as there has been so much happening lately causing poor morale, and feel I need to speak up for change. One issue that we discuss among the nurses is that management is so aggressive against staff for some errors that yes, could have had adverse effects, but didn't. As you probably know, people learn from mistakes if there is a system in place to identify what the cause, the impacting variables, and identification of ways to prevent that same mistake from happening again. But what has happened here, for example, a nurse gets written up for taking a patient's temperature on the hospice wing. What happened to the option of going to this new nurse and saying, by the way we don't take vitals on our hospice wing, please don't do it again, and thank you for the care you are giving our vets at the end of their life. I think management forgets the thank you's that are meaningful, and instead have given out little colored pieces of paper that say, things like "go team". The staff is not stupid and can tell the difference between something condescending and something heartfelt.

The recent management style has come down hard on all staff, for even the smallest infraction, threatening grave consequences for messing up. If you add this to the recent finger pointing by staff and making claims that are not necessarily accurate about other staff has added more stress for everyone. Many staff believe the situation with Penny Dugay is a set up. Isn't that sad? If you talk with the people who have worked with her, you will find out that she is one of the most loyal, dedicated and skilled nurses here, she tries so hard to keep on top of everything, and is so fair to all staff. I have never heard a negative word about her skill. I am proud to work side by side with her, and consider her an asset to this facility. Management is so quick to believe what they want, that we lose the best staff, and then many times those staff that are dangerous to staff get to stay and continue working here even unsafe. Remember the story about 3 witnesses to an auto hit and run, each telling the officer a different color of the car that got away? Our perceptions can be flawed without all the information available. People are just too quick to judgement.

But, the most important issue here causing poor moral is the staffing problems. Management has not taken the staff seriously about the problems with low staffing. We are not here trying to do as little as possible so we can sit around and socialize all shift. Most of us are hard working, extremely caring individuals and professionals that can correctly identify the needs of their unit, and we do it for the safety and quality of care of the patients. Management forgets (or maybe doesn't know) that some staff have more experience and/or education than they do. We need to engage and respect our valuable staff into the circle of problem solving, not put them down like little children. Some managment have even gone so far as to acuse other staff of causing some to leave, when in fact we all know that most are leaving because of management and and low staffing and the stress caused by all this.

Staff who are not functioning up to par in one area might better be served (as well as the VA being better served) to be placed into another position where they can excell rather than wasting everyone's time having to keep track of their mistakes and finding ways to get rid of them.

Nothing makes us feels more dedicated, more confident, more loyal than having a job that we feel we have done well with good outcomes. We can go home and enjoy our private lives, sleep well at night, and feel invigorated at the idea of coming back to work. This is just not happening at this time for most staff. Most are tired, worn out, stressed, call off a lot, increased illnesses, more headaches, worry themselves sick to death that they forgot to dot all i's and cross all t's because managment is so afraid of JACHO, we might be written up because we forgot a treatment etc.

If you are afraid of JCAHO, maybe you should be. There are so many things that are not done, not charted (which we know in a court of law means not done!), things we intended to do but never got to it because we got sidetracted too many times during the shift because we could not focus. Licensed staff are not here just to pass out pills, otherwise we could manage well with what we have. Here are a couple of examples: (and please remember that I share these not to get the staff in trouble, but to make a point

1. MR On Apr 5th which was 2nd day post op, no nursing note written during the day, no ice applied as ordered, no removal of dressing as ordered for assessment of site day shift.
2. Mr tells me he was supposed to get granulex to coccyx and MOM for his bowels, but neither happened on day shift. Found that the nurse Sara Taylor signed the treatment book that the granulex was applied. Patient does not have dementia. Sarah probably got side-tracked.
3. On MR K8832 I wrote a note and left report message for day shift on apr 5th that patient had what looked like very large herpes lesion on chest which was very painful to him, needed doc to look at it next day. Noc shift also wrote note, and did give verbal report to nurse about the lesion. This evening I asked the day shift nurse Christina Jeffers RN if she saw it, she said no, but she heard about it. I asked if she called the doc about it she said no, she didn't have time. She said the staff probably put the bacitracin on it. I said that doesn't work for viral infections. Then she said, what does it matter, he's dying anyway. I walked away, Donna Fox heard her say, It wasn't my priority today. I called NOD Sue R. who took him to ER where he was diagnosed with herpes with some possible overriding bacterial infection. **Christina** Jeffers called me later that evening to apologize as she felt so bad that she was rude to me, and that she really is a caring nurse, and had such a stressful day and admitted that she just forgot to address this problem and felt bad for the patient..

There are just so many more of these documentation issues, and more of the times when we are pulled from one wing to another, leaving no staff on that one wing until we return, just because there are not enough of us to properly care for the patients AND do all the necessary legal documentation. We are in constant fear of being written up by management or other team members. The teams have been torn apart by all this stress, some picking on each other, blame placing, when we should be guided into supporting each other during this time of staffing crisis. We inform management sometimes weeks in advance that we are short staff on a day coming up, and when that day comes up nothing has been arranged. I am not looking forward to my shift next

weekend when I'm the only licensed staff scheduled. I am looking forward to upcoming changes that will help me enjoy working here again. **And hopefully my fear for the consequences of writing a note likes this to you is unfounded.**

This letter is respectfully submitted. Thank you for listening. Looking forward to a response.
jerri

Jerri Bedell MN RN,BC CHPN

ECRC 2

My PPP report documents 2 years of increasing retaliation for my whistleblowing efforts in order to stand up for our veterans unable to take a stand for themselves. There is documentation I have provided to show that the two reasons they gave for my termination were contrived: one where I was written up 6 months prior to my firing for not following a policy, when in fact I did follow the policy and provided the actual policy as proof of my claim; the second issue was for the removal of a foley catheter without a doctors order that occurred almost 3 months prior to my termination. When in fact, if the OMI investigators had looked at the correct date for that patient's clinical record, they would have seen that there was no order against removing a foley catheter, that I did use good judgment for its removal and follow up care of the patient, and I did notify the provider of my actions, and that the patient/veteran in this case was discharged home and did provide a letter to me confirming the actions I claimed, which I provided to the investigators, and even the OMI investigators learned from management that it is the nurse's responsibility to care for a foley catheter, removing it if necessary as long as the provider is notified. Management continues to assert that I removed a catheter from a patient with an order not to, which is clearly not true and can be verified by looking at the clinical record, which no one has done as of this date. I responded to the PPP report, again stating the specifics and providing documentation to support my claims of retaliation and have heard nothing back in return.

The OMI investigators failed to even look at the correct documentation, see page 21 Findings regarding complaint C.3, where they consulted the clinical record for this patient of May 8, 2008 finding just the opposite of my claim and ruling my claim was unsubstantiated. This is one example of the poor investigative action, since I wasn't even an employee on May 8th, having been terminated in April of that year. When in fact, the date of the clinical record that should have been looked at was January 28th of that year! I have provided documentation for all these claims. The issue I was attempting to claim was the overuse of foley catheters, which the investigators did not substantiate from their findings. If they knew more of the information at hand, the unspoken rule of the unit, was that the physician wanted foley catheters in all hospice patients I believe for the convenience of the staff rather than for the comfort of the patients, which is the standard of care in hospice.

The actual reasons the VA used for my termination were contrived. Even though I was a part-time employee and can have my employment terminated for no reason at all, this VA purposely used contrived reasons of a clinical nature which has in essence lead to further unspoken retaliation...the inability to obtain further nursing employment. This VA also filed charges against me with the Inspector General's office for contacting my Senator to report some cases of patient/veteran abuses, which led to a very uncomfortable interrogation in my own home accusing me of violating privacy laws.

I continue to assert that for these reasons, the Disclosure Report is flawed immensely.

- The process of interviewing ONLY the witnesses for the VA, not one witness I provided to support the claims were interviewed even though they were fully open to giving testimony. One patient that was interviewed knows the system and knows to, as he says "keep your mouth shut" if you don't want retaliation. Another old time veteran that lives in the unit suffers recurrent abuses states "you have to pick your battles". Many veterans that seek care at the Prescott VA were just waiting for investigators to contact them to share their stories of abuse and retaliation. But not one was contacted.

- The lack of holding accountable staff, physician, and management for allowing ongoing abuses with narcotics, bowel medications, etc, abuses that were acknowledged in the findings and yet the OMI allowed the VA to just address the issues as '13 recommendations'. There was no accounting for the abuses that occurred...the physical and emotional torture to veterans who were dying and are no longer here to speak for themselves. If a proper investigation was conducted, they would have found that a threatening environment of verbal and unwritten orders were imposed on staff who followed those orders for fear of retaliation of losing their job. Some examples were 1) do not let anyone die with a full bowel, resulting in inappropriate ordering and administering of excessive amounts of bowel medication leading to veterans laying in pools of excessive explosive diarrhea 2) hide narcotic medication in patients food or liquid, patients that were refusing pain medication, 3) give the pain medication throughout the night even though the patients doesn't need it 4) do not take temperature of a hospice patient, "give Tylenol for warmth" an actual order, 5) place actively dying veterans into the hot whirlpool, often causing accelerated death, so they are clean when they die. This did often result in many dying in the whirlpool. Even though policy was put into place to prevent these issues from reoccurring, I wouldn't believe it because those examples were unwritten, and should not have been followed in the first place by any competent nurse.

- Even though the background for OMI's report states that they spoke with me and met with me while here in Prescott for their investigation was only to tell me what they were going to do. I was asked only one question which was about the definition of 'actively dying'. They would not ask me anything else, did not seem interested in anything else I stated, and in fact asked me not to report or provide any more information, as the case was already too large. I was never contacted again by them to clarify any information, even though on page 46 it states "The OMI team interviewed the complainant on multiple occasions". They did not contact the two nurses that were willing to testify about the unwritten rules and inappropriate orders from the provider along with the retaliatory environment. And in fact, if they had contacted these nurses and did a real investigation demonstrating protection for other staff, they would have found that just maybe more would have come out with the truth!

- There are many examples of fear based answers. The staff and nurses deny allegations that many will tell is true, if protected. The VA management interviewed staff and prepped them on their answers to the investigators, of course they probably didn't record that information. VA management claims they responded to all my concerns, which is flatly not true. Many things I informed the investigators about, such as the inappropriate storage and administration of medication inhalers especially to veterans with infectious MRSA was never addressed while I was there, and in fact the same poor process was in place long after I left. The issues with overuse of bowel meds and narcotics continued long after I left, and was not addressed until the OMI investigation cited them for this inappropriate action stating on page ii "However, in some cases the parameters of their use of narcotics were outside the bounds of usual practice".

- If I provided enough proof for the finding of 13 citations, what would make the investigators believe that the rest of my disclosures were unfounded just because they could not substantiate the claims I made because it seems none of them bothered to look inside the patient charts. Bizarre in light of my providing documentation of reports via email over the 3 year period to supervisors that went unanswered by management. An example of one instance had to do with the reporting of medication treatments that were found at the bedside untouched and yet the C.N.A. charted on the paper treatment record that they had administered the medication treatment. There was no way any investigator would ever find these instances in the treatment book as they were all signed for as given! The proof was in the many email reports to supervisor of the specific incident, patient, medication, date and time, so that the supervisor could do their job, look at the chart and determine who did not give the treatment and yet illegally signed that they did. This happened so many times. One RN use to collect all the medications, that were marked by the way with the patient's names on them, and give them to the supervisor. That RN became the manager of the unit by the time the investigators arrived and of course denied any of it, because of a fear for her job. I, as charge nurse at the time, use to also collect the cups and place them on the desk of the manager so she would have them when she read my email disclosing this problem. Many staff members were well aware of this problem. Many of the C.N.A.s interviewed by the investigators were the ones that were leaving the cups filled with medication in the room untouched and then signing the chart that the medication had been administered! I wouldn't be surprised that they denied all these charges. This practice never changed while I worked there, not being addressed by any management. Interviewing other witnesses and paying attention to the email documentation of my reporting these instances just might have provided additional verification for my claims. My emails could be verified by the investigators through backups performed by the IT department. I submitted nothing that backup documentation wasn't available if the investigators had only looked!

- I understand that management at the Prescott VA is working very hard to deny any disclosures of abuse or mismanagement I have made because of their retaliatory actions taken by them to terminate my employment. They have manipulated the evidence, such as leading the investigators to believe that under staffing was never an issue, that they took actions to hire agency nurses. If the investigators truly looked into the issue of staffing and interviewed some of those agency nurses that had left the VA, some even walking out without finishing their contract, they might have learned firsthand information as to how these nurses were left to cover the unit with the most minimal of staff. If the investigators would have interviewed me and other nurses about the details of this issue they would have found the proof of the short-staffing to the point of creating unsafe conditions for the veterans and the staff.

- In any other venue, the inappropriate use of narcotics, "even with clear intent to relive suffering" as stated by the OMI investigators might have generated prosecutorial actions. It appears in many of the cases cited by the OMI investigators as "unsubstantiated", and in light of biased one-sided investigation, that the OMI investigators may have been instructed to find in favor of the VA.

I assert that the Prescott VA maintained a hostile work environment, manipulating employees to follow even illegal commands, such as hiding medications in a patient's juice that the OMI could not even find, even with witnesses, but oh yes, they didn't approach the witnesses. I also assert that many of the veterans did suffer abuses at the hands of staff following inappropriate physicians orders, or just not educated or caring enough to provide the excellent care our veterans deserve. I disagree with the OMI findings that state they believe that any suffering was not purposeful. And that makes it ok? Insane to say that! The issues I reported causing abuses to veteran patients were not of ignorance, rather were a result of an environment of fear, mismanagement, ego, short-staffing, etc. I believe this because there were so many of us that were aware of what was happening, doing our best to prevent the abuses, stand

up to management and suffered the consequences of losing our jobs, retirement, reputation, and careers.

I would like to suggest another investigation needs to be undertaken by an outside and unbiased authority; otherwise you will be ignoring again the needs of our nations' veterans, many of which are now seeking VA care because of the war in Iraq and Afghanistan. I am a federal whistleblower being ignored and defamed by the government, as is other federal whistleblowers. I cannot be quieted! I am concerned! Someone needs to get at the real story, the real truth!

Respectfully submitted,

Jerri Bedell, (electronic signature)

Jerri Bedell MN RN

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San Francisco Bay Area Field Office

September 3, 2009

Ms. Jerri Bedell
P.O. Box 4464
Chino Valley, AZ 86323

Re: OSC File No. MA-08-2004

Dear Ms. Bedell:

The Office of Special Counsel has completed an investigation of your complaint of prohibited personnel practices against the Veterans Administration. You alleged that agency officials, including Robin Larson, the Geriatric Extended Care Service Line Manager, and Marianne Locke, the Nurse Executive, terminated your part-time appointment at the Northern Arizona Veterans Affairs Healthcare System (the "Healthcare System") because of your protected whistleblowing activities. 5 U.S.C. § 2302(b)(8).

Based on our investigation, we have made a preliminary determination that there is insufficient evidence to establish a prohibited personnel practice. I am reporting our findings below.

You began working as a nurse at the Healthcare System in April, 2005, under a part-time appointment. Part-time employees are temporary employees whose appointments federal agencies may terminate at any time, even without providing reasons. Nonetheless, when the Healthcare System terminated your appointment, it chose to provide reasons in a letter dated April 8, 2008. The letter cited your removal of foley catheters from patients without orders to do so and your receipt of a prior written counseling for actions which "compromised patient care."

You deny that these were the reasons for the termination of your appointment, maintaining that the "last straw" in that termination action was whistleblowing disclosures contained in an e-mail you sent to Locke on April 6, 2008. The disclosures consisted of information that you believed reflected, among other things, understaffing, mistakes on patient charts, missed drug disbursements and improper treatments.

Although these disclosures may constitute protected conduct, we cannot establish a causal connection between them and the termination of your appointment. The evidence showed that the decision to terminate your appointment was made well before you sent your e-mail. Almost one month earlier, your supervisor contacted an employment

relations specialist by e-mail inquiring about the proper procedure for terminating your appointment. Other e-mails written before April 6 also address this topic. Not only do these e-mails demonstrate that the decision to terminate your appointment was made before your April 6 disclosures, they support Locke's testimony that when she read your e-mail of April 6, she did not respond because she already knew that your appointment would be terminated on April 8.

We have also examined the possibility that other whistleblowing disclosures, which you made even before your "last straw" disclosures of April 6, may have caused your appointment to be terminated. Your supervisors testified, however, that your appointment was terminated for the reasons they set forth in the letter notifying you of the termination of your appointment. Most importantly, the letter charged you with removing foley catheters from patients without permission on several occasions. You acknowledged that you engaged in this conduct, but asserted that you were justified in doing so because you wanted to make patients more comfortable or because the catheters were leaking. You furnished no support for the position that you could overrule the medical decisions of the doctors and nurse practitioners who ordered the insertion of the catheters. Moreover, the nurse practitioner responsible for the patients involved, as well as your supervisor, testified that a nurse may not make medical decisions regarding the need for a catheter without obtaining the approval of a doctor or nurse practitioner. This testimony was consistent with the standard Lippincott Procedures for the removal of catheters, which indicate that catheters may be removed only based on a doctor's order. In light of this evidence, combined with the wide discretion possessed by agencies in making decisions to terminate temporary appointments, we could not successfully challenge the grounds for terminating your appointment.

For these reasons, we have determined that the evidence was insufficient to prove that the termination of your appointment was a prohibited personnel practice under 5 U.S.C. § 2302(b)(8). Nevertheless, before we make a final decision in this matter, we would like to provide you with 13 days to submit any written comments that you would like us to consider. You may send them to me at the above-listed address or to my e-mail address, jsiegelman@osc.gov.

Sincerely,

Joseph E. Siegelman
Senior Trial Attorney

Response to Investigation

RE: OSC File No. MA-08-2004

Date: November 13, 2009

Dear Mr Siegelman,

In your letter you claim that the disclosures I made "may" constitute protected conduct, but that you cannot establish a causal connection between them and my termination from employment.

I am asserting that because of my reports to management over a 3 year period of time, of inappropriate treatments and care that resulted in nothing less than what can be considered emotional and physical abuse to veterans by some staff and some providers, that management decided to find a way to remove me from employment, rather than address the issues I was reporting. The last couple months of my employment, the issue of short-staffing was rearing its ugly head just about every day, myself and other nurses , whom you failed to contact for substantiation, reporting this issue each time as our concern for the safety of the veteran patients and for the staff providing the care. And in fact, on one occasion I was verbally reprimanded for telling a physician that we were understaffed for the number of patients and the care needed to be provided to them that evening. The physician was upset and said she would correct the problem. Of course the manager she notified was Robin Larson, who was the one that did the reprimanding. The "word" on the unit after that time was that Robin Larson was going to get rid of the evening shift nurses because we were "trouble-makers". This time period is what you refer to as the emailing inquiries about the proper procedure to terminate my employment. How do you think I know this? Because Robin Larson blabbed this to other staff she felt were friendly to her side. These staff members are scared to death of losing their jobs if they spoke up!

Attachment 1 is a copy of a letter that was given to Robin Larson by Caroline Dugay RN on April 26, 2008 as part of a required response to Robin's continued threat of firing Caroline, after I was fired. Robin gave Caroline such a difficult time, she transferred to another VA out of state before Robin would have her terminated. Caroline Dugay is and has been always willing to speak to investigators about this, but has never been contacted. The third nurse of the evening shift, Kim Wheeler RN, also was given a very hard time by Robin Larson, and Kim resigned due to the fear of being fired. Kim Wheeler RN is and has been always willing to speak to investigators about the witchhunt, the retaliatory actions by Robin Larson for reporting abuses and safety issues, but has never been contacted.

A proper investigation is impeded for the following reasons:

- There are many employees that can corroborate my side of the story because we all lived through it. Unfortunately, the environment of fear permeates this facility, fear of telling the truth and you'll be fired...just like Jerri Bedell and the others! No matter how many times they tell the staff that there is no retaliation for whistle-blowing, no one believes this!

- The nurses that are no longer there, many having left of their own accord prior to being fired, can validate all these issues, but only if you contact them, and you have not. You cannot believe that they are all disgruntled ex-employees. The sad and disheartening part of this is that we were all excellent nurses and staff, providing excellent care, and because we stood up and took a stand to protect the veterans, we were the ones who lost our jobs doing a good job and standing up for what was right. Unfortunately, management spent their time trying to find a way to terminate me, and others, instead of just addressing the issues, and for some reason management is supported in whatever they say, and the abuses continue.
- You have to realize that management is going to do whatever they can, and say whatever they can to protect themselves. They truly are only one side of the story. The other side has not been interviewed, so how can you call this an impartial investigation. Maybe you didn't, maybe it was what I expected and hoped for... for the sake of the veterans.

As for the supervisors testifying that my employment was terminated for the reasons stated in my letter of termination, I can tell you this is their poor attempt to cover-up the actions mentioned above. You don't really believe they would admit to firing me for whistleblowing? I will address each issue separately.

1) "...on several occasions you have removed foley catheters from patients without orders to do so. This has the potential for compromising patient care."

   I removed one foley on Dec 30, 2007 on one patient, and one foley on Jan 28, 2008 on another patient. There were NO orders on these patients to NOT remove the foley catheters. I submitted to the OSC specifics such that these patients clinical records could be reviewed. I never stated I did this just for comfort as you suggest. I removed them for serious issues compromising physical and emotional health of these patients. Both patients had Foleys with blocked urine flow and blood clots, pain and discomfort, and most of all serious risk of further physical injury to these patients if catheters were left intact. These patients were on the hospice unit. Catheters used on the hospice unit are for the comfort of the patient. Both times my charting reflected my actions, my reasons, my competent care for these patients, the continued monitoring of urination after removing the Foleys, AND most of all the that these electronic notes were in fact sent to the provider (the nurse practitioner Betty Sue Zager) to notify her of my action, the reasons for the actions, and the positive outcome of these actions.

   I did in fact follow standard nursing procedures for the removal of foley catheters as stated in Lippincott Procedures Manual (see copies of pages attached 2 through 5, nowhere on these pages does it claim that a nurse needs a doctors order to remove a foley catheter. It does state on page 718 "An indwelling urinary catheter should be removed when bladder decompression is no longer necessary, when the patient can resume voiding, or when the catheter is obstructed." On page720 it states "Change the indwelling catheter, as ordered, or when malfunction, obstruction, or contamination occurs."

And the fact that both patients did better without the foley, especially since they were not functioning correctly. I provided the patients names to the OSC lawyer, and you have the dates, and all this information can be viewed by looking into the electronic record.

According to the OMI's investigation into this matter, "The hospice physician admission orders from CPRS do include, among other routine orders, the option to select "Foley/Straight cath PRN" and "Change Foley PRN". These two patients that I removed the foley catheters had the orders for the first option. The OMI investigation also reports that "Ordinarily, the nursing staff is allowed to exercise their independent judgement about whether to insert or remove a catheter." Unless the provider writes a specific order not to remove a foley, which was not the case with these two patients!

In fact, the nurse practitioner is claiming that I removed a foley catheter from a patient AFTER she had written an order stating the foley catheter was not to be removed without her permission. This is not true! This patient was in fact a different person than the two I removed catheters from, was written on Jan 30th, and I did not even provide care for this patient. If you were to review this patient's record, you would see this fact, and that I did not remove his catheter! The nurse practitioner wrote this order because she didn't want anyone overriding her orders, an ego issue, even though the actions may be taking better care of her patients. See attachment 6, which is email I sent to the other nurse practitioner at her request on FEB 2, 2008, the numbers are blacked out, the OSC lawyers have the original with the identities. There was never any response back from Lori McCoy, or any supervisor, or anyone else about this issue after FEB 2, 2008. I was never written up for anything after Feb 2, 2008, why did it take them so long to terminate me for this issue, and according to you the emails with human resources started "almost one month earlier" than my termination date. What do you think made them wait so long?

From the Prescott Daily Courier, an interview by reporter T.M. Shultz in article dated August 30, 2008 states when asking if nurses can remove foley catheters, the response was " Locke - an RN herself a nurse - and Dr. Walavalker emphatically stated in a July 3 interview with The Daily Courier that a nurse should immediately remove a bloody, overflowing catheter from a patient and does not need "orders" to do so." "We have told the nurses to use their judgment," Walavalker said. The tape recorded interview is available from this reporter, if you would only contact her.

So in fact, I did not remove any foley catheters without permission! And I did notify the provider (the nurse practitioner) of my actions, documented by the clinical record for the two I did remove. My actions did improve patient status, preventing further and possibly traumatic complications. The only reason management is maintaining their claim is to have a reason to terminate my employment.

I know and the other staff knew that the nurse practitioner Betty Sue Zager and Dr Walavalker did not like anyone questioning their orders. Another example I gave for your investigation was

about a patient that was brought to the floor from the ER by the nurse practitioner and she ordered his IV fluid to be run at a full out rate which was about 400 cc per hour, and then she went home. First of all, that rate is not allowed on that extended care unit by policy, which I provided a copy, allows only a rate of 250 cc per hour. Any higher the patient would have to be cared for in the ER or the main hospital. I was the charge nurse that evening, called the on-call doctor, explained the situation, and he changed the order to reduce the rate to the appropriate amount. The second issue, and more important than the policy was that the patient was an older person in his 80's who was found in his house collapsed, and now was severely dehydrated. Running IV fluids too fast into a compromised older adult can lead to fluid overload and heart failure. The next day the nurse practitioner was angry that I overruled her order. The witness to this situation was the other nurse management tried to fire, Kim Wheeler RN, who is and always was available to give testimony to this example. This example happened within the time frame of the issue with the catheter removals. Dr Walavalker was known to go to the supervisor, Yvette Hankerson at that time, and demand she write-up/punish nurses that questioned her orders or treatments. Kim Wheeler RN was written-up for taking a temperature on a patient in the hospice unit. There were no orders preventing this action. This was one of Dr Walavalker's spoken only orders... there will be no oral temperatures taken on patients in the hospice unit. This is ridiculous and inappropriate care for a hospice patient. It is up to the nurse to make that kind of decision. Dr Walavalker placed an open order stating "Tylenol for Warmth". Sometimes people are warm because of the dying process, because of the heat in the room, or too many blankets, not always fever. Medicating patients with Tylenol for warmth when there are just too many blankets is inappropriate. Caroline Dugay RN, also almost fired, questioned Dr Walavalker's order for giving a patient the medication Levsin too often, every 10 minutes. Dr Walavalker was upset that the wife was in the room and complaining about the noise from the death rattle, and yelled at the nurse for not following her order and giving multiple doses as often as she wanted. More of that medication does not work the way she wanted, and in fact too much of the medication actually causes severe agitation, and most likely hastened his death. Dr Walavalker told the supervisor of that issue and the she no longer wanted Caroline Dugay RN to work the hospice unit. One of the dayshift nurses, Catherine LeBlanc RN, befriended Dr Walavaker and they had been seen out partying together at bars by staff. It was Catherine LeBlanc that lied to the supervisors about me, saying I had refused to admit a patient on my shift. There is no reason I would ever, ever say that or do that. It is just plain ridiculous. We all knew that Catherine LeBlanc was friends with the supervisor Yvette Hankerson and Dr Walavalker and was constantly reporting people to get them in trouble. After I left employment, the new supervisor finally had all the info and the complaints about Catherine LeBlanc and she was terminated. That did me no good.

2) This leads into the 2nd reason they gave for my termination titled Letter of Verbal Counseling (Failure to follow policy and procedures), in which it states "On 10/11/07, a patient was admitted to ECRC 2, late in the afternoon and the RN TM was to be completed by you, but it was not completed. You failed to follow the proper procedure for caring for the patient. The patient's assessment was **delayed until the oncoming shift**." See Attachment 7

As stated above, how Catherine LeBlanc lied to supervisors stated I said I would not do the admission. In fact, the policy states the admission shall be completed within 24 hours, not 8 as Yvette Hankerson was telling me. See Attachment 8. I tried to tell her about the policy and she was forceful in saying I didn't know what I was talking about, that it was 8 hours. And, if I didn't sign it, I would be fired. I had never been written up before, also knew they were on witchhunt writing up the other staff for silly things, and so I didn't do anything about it. I should have taken it to a committee and had it removed from my file.

As for this patient that was admitted, this actually happened on the shift prior to mine when Catherine LeBlanc was the charge nurse and she did not admit him on her shift, passing it on to me to do. That shift did nothing to help this man, who was a quadriplegic just transferred back to Prescott from the VA in San Diego rehab unit where he had reached full potential with them as he was not trying to help himself anymore. They transferred him in stable in condition. When I came on shift and found him lying in his bed with no ability to call for help except to yell. They had left him there in pain, giving him no water and he couldn't pick up a glass on his own. I tried twice to do the admission paperwork with him which does take a couple hours, but does need his participation. Once he became sick from the pills and began vomiting, and the 2nd time he tried but told me he couldn't do anything as he was too exhausted from his 8 hour ride that day. I charted this information in the clinical record. When I was receiving the letter of counseling, Yvette Hankerson told me that I didn't even chart on him. I reassured her that I did noting that I attempted twice to complete the admission process and then she backed down. She hadn't even read the chart, only believed what she was told! In fact, on that evening, that paralyzed patient was so scared and in pain and needy for help that I assigned George Vetner C.N.A. to actually stay with him one-on-one to relieve his anxiety and help him be comfortable by repositioning frequently for pain relief. This patients' injury resulted in paralysis but he could still feel everything! Therefore, this patient, received more than excellent care that shift, having staff with him all the time. And, in fact, the Lippincott Procedure Manual, that the VA so closely follows, on page 3 states in reference to the admission assessment that "During this assessment, the nurse must prioritize the patient's needs, and she should always be conscious of the patient's levels of fatigue and comfort. The admission process can be exhausting.... When the patient is experiencing physical or psychological problems, the nurse should decide whether any portion of the admission assessment can be postponed." (see attachment 9)

I take all of this matter seriously. I am an honest, ethical, and dedicated nurse. I have a Masters Degree in Nursing and have taught nursing at the associate and baccalaureate levels. I pride myself in excellent care. During my employment at this VA, there were many more issues that I

didn't report, because I am aware of the realities of health care...it is not perfect! But, in the issues I have reported, I don't believe there was any good reason for those actions that I and others deemed abusive to patients. I always tried to do it nicely and many times said I would help solve the problems, teach better ways, etc. I even started a committee for just this process and also developed an educational program for one issue. I joined the committee for Evidence Based Practice and even developed a protocol for one issue, having the committee compliment me for being the first person to actually get something accomplished in this committee. But that protocol when sent on to Marianne Locke, the nurse exec, who put it aside, stating that the nutrition committee was looking into the issue. The rest of my tenure at the VA, I never did see any changes to that issue.

I know, and showed the lawyers at the OSC through documentation, that Robin Larson followed a path of retaliation after I went above her head to the past nurse exec back in 2006 to report a problem that Robin was ignoring. If you even looked at my evaluation from Robin when she was my supervisor, you will see that it is glowing and excellent. The next evaluation from Karen Martin, occurring after Robin's anger with me for going over her head, was actually rewritten by Robin. My supervisor Karen Martin wrote it first and delayed it almost 5 months saying Robin had it, and then told me Robin rewrote it. You can see some of the same verbiage on both. This one was very derogatory. I know and other staff know, that Robin was on a mission to have me terminated. I never did anything wrong, just reported abuses, which she never did anything about. There are many things I just can't prove and of course Robin probably denies this.

When I filed this complaint of PPP, I submitted approximately 50 pages of documentation, showing the multiple things that I reported as abuse through the time I was there as an employee. One of the providers at this VA who I was friendly with told me that management fired me because "they were intimidated by you". I can't prove everything. You just have to put the pieces together like a puzzle and see the whole picture. And this means actually interviewing the people that are witnesses for my claims. You haven't even interviewed me!

Hopefully I have substantiated my claims about the reasons for my termination as being false on their part, which I believe is abusive and retaliatory to me on the part of management for bringing issues to light they didn't want to acknowledge. I also challenge the part of "part-time employees are temporary employees". My designation on my paperwork stated PERMANENT PART TIME. I do realize any employee can be terminated without reason, but I do believe it is illegal to terminate my employment for the wrong reason and thus hindering my career. I am fighting the way they did it, making false allegations via truth twisting, terminating my employment, which I assert is the retaliation for my ongoing process of reporting/disclosing abuses to Veteran patients.

Sincerely,

Jerri Bedell

Included are 9 Attachements

November 2, 2007

On October 12th at approximately 2045 Mr. S[redacted] was brought back to the floor by a VA policeman. I was in the last room on B Hall admitting a new patient, Mr. R., when the CNA advised me that Mr. S[redacted] was missing. I immediately dropped what I was doing to search for the vet. When I got to the nurses station, I could see Mr. S[redacted] coming down the hall with the Policeman. I did have the CNA place a wanderguard on the vet and we continued to monitor his whereabouts.

Earlier at beginning of shift I requested another CNA from the NOD, Sharon Dublin, and was told that there were no other CNAs available in the Facility therefore I would have to work with only 3 CNAs. I advised here that this was a safety issue because I would not be able to watch the floor and do a new admission because it takes approximately 2 hours to complete one. I asked her if she could help me with the admission due to the high level of acuity of the floor and high census on Hospice. My request was denied and I never saw the NOD the rest of the evening.

Very truly yours,

Caroline Dugay RN

2

Lippincott's Nursing Procedures

FIFTH EDITION

Wolters Kluwer | Lippincott Williams & Wilkins

Philadelphia • Baltimore • New York • London
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Home care

If the patient will be discharged with a long-term indwelling catheter, teach him and his family all aspects of daily catheter maintenance, including care of the skin and urinary meatus, signs and symptoms of urinary tract infection or obstruction, how to irrigate the catheter (if appropriate), and the importance of adequate fluid intake *to maintain patency*. Explain that a home care nurse should visit every 4 to 6 weeks, or more often if needed, *to change the catheter*.

Complications

Urinary tract infection can result from the introduction of bacteria into the bladder. Improper insertion can cause traumatic injury to the urethral and bladder mucosa. Bladder atony or spasms can result from rapid decompression of a severely distended bladder.

Documentation

Record the date, time, and size and type of indwelling catheter used. Also describe the amount, color, and other characteristics of urine emptied from the bladder. Your facility may require only the intake and output sheet for fluid-balance data. If large volumes of urine have been emptied, describe the patient's tolerance for the procedure. Note whether a urine specimen was sent for laboratory analysis.

SELECTED REFERENCES

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Taylor, C., et al. *Fundamentals of Nursing: The Art and Science of Nursing Care*, 6th ed. Philadelphia: Lippincott Williams & Wilkins, 2008.

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[illegible] CARE [illegible]

Intended to prevent infection and other complications by keeping the catheter insertion site clean, routine catheter care typically is performed daily after the patient's morning bath and immediately after perineal care. (Bedtime catheter care may have to be performed before perineal care.)

Studies suggest that catheter care should include daily cleaning of the meatal-catheter area. The use of topical antibiotics is discouraged because it hasn't been proven to be effective in decreasing infection. The equipment and the patient's genitalia require inspection twice daily.

Catheter surfaces and balloons that are exposed to urine will develop encrustations, and patients whose catheters develop a blockage have urine that's alkaline and high in concentrations of mucin, protein, and calcium salts. For this reason, it's recommended that catheterized patients drink lots of fluids to ensure increased urine output so that microorganisms are flushed out of the bladder.

Be sure to assess the catheter every day for crystals or encrustations by palpating it between your fingers and assessing for sandy or granular materials. Be careful not to break off any crystals. If encrustations are present on the catheter, it should be removed and replaced.

An indwelling urinary catheter should be removed when bladder decompression is no longer necessary, when the patient can resume voiding, or when the catheter is obstructed. Depending on the length of the catheterization, the practitioner may order bladder retraining before catheter removal.

Equipment

For catheter care: Soap and water, sterile gloves, sterile 4" × 4" gauze pads, basin, washcloth, leg bag or adhesive tape, collection bag, waste receptacle, optional: safety pin, rubber band, gooseneck lamp or flashlight, adhesive remover, specimen container.

For catheter removal: Gloves, 10-ml syringe with a luer-lock, bedpan, linen-saver pad, optional: clamp for bladder retraining.

Implementation

Confirm the patient's identity using two patient identifiers according to your facility's policy.

Explain the procedure and its purpose to the patient.

Provide the patient with the necessary equipment for self-cleaning, if possible.

Provide privacy.

Catheter care

Make sure the lighting is adequate *so that you can see the perineum and catheter tubing clearly*. Place a gooseneck lamp at the bedside, if needed.

Inspect the catheter for any problems, and check the urine drainage for mucus, blood clots, sediment, and turbidity. Then pinch the catheter between two fingers *to determine*

if the lumen contains any material. If you notice any of these conditions (or if your facility's policy requires it), obtain a urine specimen from the specimen collection port. Collect at least 3 ml of urine. Notify the practitioner about your findings.

Inspect the outside of the catheter where it enters the urinary meatus for encrusted material and suppurative drainage. Also inspect the tissue around the meatus for irritation or swelling.

Remove the leg band, or if adhesive tape was used to secure the catheter, remove the adhesive tape. Inspect the area for signs of adhesive burns—redness, tenderness, or blisters.

Put on the sterile gloves. Clean the outside of the catheter and the tissue around the meatus using soap and water. *To avoid contaminating the urinary tract,* always clean by wiping away from—never toward—the urinary meatus using soap and water. Use a dry gauze pad to remove encrusted material.

Remove your gloves, reapply the leg band, and reattach the catheter to the leg band. If a leg band isn't available, tear a piece of adhesive tape from the roll.

To prevent skin hypersensitivity or irritation, retape the catheter on the opposite side.

Most drainage bags have a plastic clamp on the tubing *to attach them to the sheet.* If this isn't available, wrap a rubber band around the drainage tubing, insert the safety pin through a loop of the rubber band, and pin the tubing to the sheet below bladder level. Then attach the collection bag, below bladder level, to the bed frame.

If necessary, clean residue from the previous tape site with adhesive remover. Then dispose of all used supplies in a waste receptacle.

Catheter removal

Wash your hands.

Assemble the equipment at the patient's bedside. Explain the procedure and tell him that he may feel slight discomfort. Tell him that you'll check him periodically during the first 6 to 24 hours after catheter removal *to make sure he resumes voiding.*

Put on gloves. Place a linen-saver pad under the patient's buttocks. Attach the syringe to the luer-lock mechanism on the catheter.

Pull back on the plunger of the syringe. *This deflates the balloon by aspirating the injected fluid.* The amount of fluid injected is usually indicated on the tip of the catheter's balloon lumen and in the patient's chart.

Grasp the catheter and pinch it firmly with your thumb and index finger *to prevent urine from flowing back into the urethra.* Before doing so, offer the patient a bedpan. Gently pull the catheter from the urethra. If you meet resistance, don't apply force; instead, notify the practitioner.

Measure and record the amount of urine in the collection bag before discarding it. Remove and discard gloves, and wash your hands. For the first 24 hours after catheter removal, note the time and amount of each voiding.

Special considerations

Some facilities require the use of specific cleaning agents for catheter care, so check your facility's policy manual before beginning this procedure.

Use a closed drainage system, whenever possible, *to decrease the patient's chance of getting a urinary tract infection.*

Avoid raising the drainage bag above bladder level. *This prevents reflux of urine, which may contain bacteria. To avoid damaging the urethral lumen or bladder wall,* always disconnect the drainage bag and tubing from the bed linen and bed frame before helping the patient out of bed.

When possible, attach a leg bag *to allow the patient greater mobility.* If the patient will be discharged with an indwelling catheter, teach him how to use a leg bag. (See *Teaching about leg bags,* page 720.)

Encourage patients with unrestricted fluid intake to increase intake to at least 3,000 ml per day. *This helps flush the urinary system and reduces sediment formation.*

After catheter removal, assess the patient for incontinence (or dribbling), urgency, persistent dysuria or bladder spasms, fever, chills, or palpable bladder distention. The patient should void within 6 to 8 hours after catheter removal.

When changing catheters after long-term use (usually 30 days), you may need a larger size catheter *because the meatus enlarges, causing urine to leak around the catheter.*

Home care

Instruct patients discharged with indwelling catheters to wash the urinary meatus and perineal area with soap and water twice daily and the anal area after each bowel movement.

Teaching about leg bags

A urine drainage bag attached to the leg provides the catheterized patient with greater mobility. *Because the bag is hidden under clothing,* it may also help him feel more comfortable about catheterization. Leg bags are usually worn during the day and are replaced at night with a standard collection device.

If your patient will be discharged with an indwelling catheter, teach him how to attach and remove a leg bag. To demonstrate, you'll need a bag with a short drainage tube, two straps, an alcohol pad, adhesive tape, and a screw clamp or hemostat.

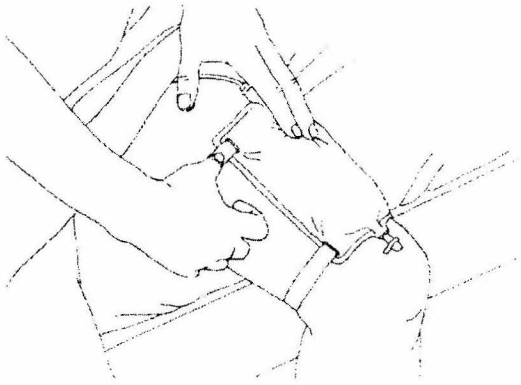
Attaching the leg bag

Provide privacy and explain the procedure. Describe the advantages of a leg bag, but caution the patient that a leg bag is smaller than a standard collection device and may have to be emptied more frequently.

Remove the protective covering from the tip of the drainage tube. Then show the patient how to clean the tip with an alcohol sponge, wiping away from the opening *to avoid contaminating the tube.* Show him how to attach the tube to the catheter.

Place the drainage bag on the patient's calf or thigh. Have him fasten the straps securely as shown, and show him how to tape the catheter to his leg. Emphasize that he must leave slack in the catheter to minimize pressure on the bladder, urethra, and related structures. *Excessive pressure or tension can lead to tissue breakdown.*

Also tell him not to fasten the straps too tightly *to avoid interfering with his circulation.*



Avoiding complications

Although most leg bags have a valve in the drainage tube that prevents urine reflux into the bladder, urge the patient to keep the drainage bag lower than his bladder at all times *because urine in the bag is a perfect growth medium for bacteria.* Caution him not to go to bed or take long naps while wearing the drainage bag.

To prevent a full leg bag from damaging the bladder wall and urethra, encourage the patient to empty the bag when it's only one-half full. He should also inspect the catheter and drainage tube periodically *for compression or kinking, which could obstruct urine flow and result in bladder distention.*

Tell the patient to wash the leg bag with soap and water or a bacteriostatic solution before each use *to prevent infection.*

Complications

Sediment buildup can occur anywhere in a catheterization system, especially in bedridden and dehydrated patients. To prevent this, keep the patient well hydrated if he isn't on fluid restriction. Change the indwelling catheter, as ordered, or when malfunction, obstruction, or contamination occurs.

Acute renal failure may result from a catheter obstructed by sediment. Be alert for sharply reduced urine flow from the catheter. Assess for bladder discomfort or distention.

Urinary tract infection can result from catheter insertion or from intraluminal or extraluminal migration of bacteria up the catheter. Signs and symptoms may include cloudy urine, foul-smelling urine, hematuria, fever, malaise, tenderness over the bladder, and flank pain.

Major complications in removing an indwelling catheter are failure of the balloon to deflate and rupture of the balloon. If the balloon ruptures, cystoscopy is usually performed *to ensure removal of any balloon fragments.*

Documentation

Record the care you performed, any modifications, patient complaints, and the condition of the perineum and urinary meatus. Note the character of the urine in the drainage bag, any sediment buildup, and whether a specimen was sent to the laboratory for analysis. Also record fluid intake and output.

6

Subject: use of foley caths
From: BEDELL.JERRI@PRESCOTT.MED.VA.GOV
Date: 2 Feb 2008 23:41:48 -0700 (MST)
To: BEDELL.JERRI@PRESCOTT.MED.VA.GOV, MCCOY.LAURIE_K@PRESCOTT.MED.VA.GOV, jbedell@CABLEONE.NET

Hi Laurie,

On Mr S [redacted] in hospice, Dec 30 I removed foley due to excess leaking, and so much blood, he kept yanking at it. After that urine was yellow, and he was voiding fine. Jan 1 Kelley CNA put cath back in, no order or note by nurse or provider to put it back in and of course the bleeding started again. The order is usually straight cath prn for comfort, but seems like they put foleys in all hospice patients.

On 1/28 I removed foley from Mr H [redacted] in hospice, for same reason, leaking too much, and he was getting ready for discharge from hospice, doing so well, not dying now anyway, and no one knew any reason for him having a foley, and of course he did get UTI. Removed it, and monitored him for residuals and he did well.

→ A totally DIFFERENT PATIENT = 'H' Letter for LAST NAME!

On 1/30 for Mr H [redacted] Sue Zager wrote order "Do not discontinue foley without this providers order". I'm sure not challenging her, just providing good nursing care with proper nursing judgement. This patient they could have just straight cathed him.

anyway, let me know if you have any suggestions for me how to deal with this. Thanks, jerri

7

Northern Arizona
VA HCS

Memorandum

Date: October 26, 2007

From: Yvette Hankerson, BSN, Nurse Manager ECRC 2

Subj: Letter of Verbal Counseling (Failure to follow policy and procedures)

To: Jerri Bedell, ECRC 2

The undersigned have met to discuss Jerri Bedell failure to As a consequence of your actions, patient care was compromised. This meeting constitutes a formal, verbal, counseling. The following specific items were discussed in this meeting:

1. On 10/11/07, a patient was admitted to ECRC 2, late in the afternoon and the RN TM was to be completed by you, but it was not completed. You failed to follow the proper procedure for caring for this patient. The patient's assessment was delayed until the oncoming shift.

2. Additional failure to follow hospital policy and procedures may lead to progressive disciplinary action.

3. A copy of this counseling will be retained by me for no longer than six months, unless it becomes necessary to place you on sick leave certification.

4. If there are personal matters adversely affecting your job performance, I can help you in contacting the Employee Assistance Program.

Signature of Employee Date

Signature of Supervisor Date

#9

Northern Arizona VA HCS
Prescott, Arizona

GERIATRICS & EXTENDED CARE POLICY #43

February 2005

MANAGEMENT OF CARE BY ECRC INTERDISCIPLINARY TREATMENT TEAM

1. INTRODUCTION: An Interdisciplinary Treatment Team (ITT) is responsible for the management and the outcome of care for Extended Care and Rehabilitation Center (ECRC) patients. The ITT includes representatives from the disciplines of nursing, dental, nutrition, recreation, chaplain, social work, rehabilitation therapies, and medicine. Some components of care may have to be provided outside the ECRC by consultants but will be coordinated by the ITT.

2. POLICY: The ITT shall develop and maintain a systematic, sequential, individualized, written plan of care for each patient in ECRC. All disciplines comprising the treatment team are expected to fully contribute expertise to the provision of quality care. The plan of care shall be based on a comprehensive assessment using the computerized Resident Assessment Instrument (RAI) of the Minimum Data Set (MDS).

3. DEFINITIONS: Minimum Date Set (MDS): A standardized assessment/care plan system designed for Long Term Care that uses the Resident Assessment Instrument to generate a plan of care for patients.

4. PROCEDURES:

a. ADMISSION ASSESSMENT AND INTERIM PLAN OF CARE: Within 24 hours of admission to ECRC, an initial assessment shall be completed by a registered nurse using the ECRC Interdisciplinary Team not in CPRS. An interim plan of care will be established from the assessment data and physician orders for the first two weeks after admission.

A medical assessment will be completed within 48 hours of admission and contribute further information to the interim plan of care.

b. COMPREHENSIVE ASSESSMENT USING RAI: The ITT shall complete comprehensive assessments within 14 days of admission using the MDS.

c. PLAN OF CARE: A plan of care shall be formulated which incorporates the RAI collaborative assessment of patient problems, needs, abnormalities in the aging process with patient/family input. The plan of care will include:

1) Resident problems and appropriate interventions:

ADMISSION, TRANSFER, AND DISCHARGE PROCEDURES

ADMISSION

Admission to the nursing unit prepares the patient for his stay in the health care facility. Whether the admission is scheduled or follows emergency treatment, effective admission procedures should accomplish the following goals: confirm the patient's identity using two patient identifiers according to your facility's policy, and assess his clinical status, make him as comfortable as possible, introduce him to his roommates and the staff, orient him to the environment and routine, and provide supplies and special equipment needed for daily care.

Nurses should be directly involved in the admission process—assigning a patient to a room, making sure that the necessary diagnostic tests are completed, and providing for continuity of care when the patient is admitted. Admitting personnel should confer with the nursing staff to make sure that the patient's room assignment is based on the patient's condition, health care needs, and personal preferences. Consideration of these factors during the admission process reduces the patient's anxiety and promotes cooperation, contributing to the patient's recovery.

The initial contact with the patient sets the foundation for your relationship. Be prepared to give the patient and his family, if present, your undivided attention during the admission process. Taking the time to listen to and assess your patient fulfills his physiologic and safety needs and establishes a therapeutic relationship. When orienting the patient and his family to the facility's routine, remember to mention that two or more nurses may care for the patient (depending on shift requirements) during his hospitalization.

The Joint Commission requires that each patient have an admission assessment performed by a registered nurse. During this assessment, the nurse must prioritize the patient's needs, and she should always be conscious of the patient's levels of fatigue and comfort. The admission process can be exhausting, especially when the patient is delayed in the admitting office for a room assignment. When the patient is experiencing physical or psychological problems, the nurse should decide whether any portion of the admission assessment can be postponed.

It's also important to maintain the patient's privacy while obtaining his health history. According to the Patient Care Partnership, the patient has the right to expect this. Examination, consultation, and treatment should be conducted in a way that protects the patient's privacy.

Admission routines that are efficient and show appropriate concern for the patient can ease his anxiety and promote cooperation and receptivity to treatment, thus contributing to his recovery. Conversely, admission routines that the patient perceives as careless or excessively impersonal can heighten anxiety, reduce cooperation, impair his response to treatment, and perhaps aggravate symptoms.

Equipment

Gown personal property form valuables envelope admission form nursing assessment form thermometer emesis basin bedpan or urinal bath basin water pitcher, cup, and tray urine specimen container, if needed.

An admission pack usually contains soap, comb, toothbrush, toothpaste, mouthwash, water pitcher, cup, tray, lotion, facial tissues, and thermometer. *Because the patient's pack is included in his bill,* he can take it home with him. *An admission pack helps prevent cross-contamination and increases nursing efficiency.*

Preparation of equipment

Obtain a gown and an admission pack.

Position the bed as the patient's condition requires. If the patient is ambulatory, place the bed in the low position; if he's arriving on a stretcher, place the bed in the high position. Fold down the top linens.

Prepare any emergency or special equipment, such as oxygen or suction, as needed.

Implementation

Adjust the room lights, temperature, and ventilation.

Make sure all equipment is in working order before the patient's admission.

Admitting the adult patient

Speak slowly and clearly, greet the patient by his proper name, and introduce yourself and any staff present.

Confirm the patient's identity using two patient identifiers according to your facility's policy. Verify the name and its spelling with the patient. Notify the admission office of any corrections.

Quickly review the admission form and the practitioner's orders. Note the reason for admission, any restrictions on activity or diet, and any orders for diagnostic tests requiring specimen collection.