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Letter: VA hospital attitude condescending

Friday, September 19, 2008

EDITOR:

As a nurse whose ex-husband was a veteran and whose oldest son is also a veteran, both of whom have received care from the VA system, I'm shocked at what I interpret as the cavalier attitude of the administration at Prescott VA.

Nurses such as Jerri Bedell rarely take complaints to the level she has unless they have a fervent belief that something is wrong or that the patients are in danger.

I also found the Prescott VA officials' dismissal of patient family concerns as "misinterpreting what they see" as condescending. It has been my experience that families rarely "misinterpret" what they see, and if anyone suspects "misinterpretation," then the nurse or administrator need only have a conversation with the family to answer and clarify matters - this usually resolves any "misinterpretation."

Kudos to Nurse Bedell for standing up for her patients, nurses and herself, because far too often nurses take the easy way out and simply turn a blind eye.

When nurses and other health care providers make such principled stands, we have an opportunity to peel back the "White Coat of Silence" on unsafe and dangerous practices.

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Feds pursue local nurse's whistleblower complaint against Prescott VA

By T.M. Shultz

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whistleblower complaint filed in May against Prescott's Northern Arizona Veterans Affairs Health Care System, said James Mitchell, chief of staff and director of communications for the OSC.

Registered nurse Jerri Bedell said she was fired from the Prescott VA's Community Living Center two days after writing a lengthy letter to a supervisor outlining her concerns about abuse and neglect of veteran patients.

Bedell - who has a master's degree in nursing with additional certification in geriatric care and more than 20 years experience nursing and teaching - worked at the center for three years.

Mitchell said the OSC assigned an investigator in its San Francisco office to the case on Aug. 25. The OSC investigates cases only that it believes it has adequate evidence of proving, Mitchell explained.

"It's possible our investigator would go to Prescott in the course of the inquiry," Mitchell added.

He said the investigation - which is concerned only with whether

The United States Office of Special Counsel has decided to pursue a federal

Bedell helped launch 2005 drug investigation

By T.M. SHULTZ

The Daily Courier

Registered nurse Jerri Bedell's persistence helped launch a federal investigation three years ago that led to the indictment of a nurse for stealing 166 oxycodone tablets from the Northern Arizona Veterans Affairs Health Care System's Community Living Center in Prescott.

Mila Somerlik, a Czechoslovakian citizen, originally pleaded guilty to one count of obtaining a controlled substance by fraud or forgery, which is a felony, and one count of theft of government property, which is a misdemeanor.

However, the judge deferred sentencing for a year under a plea agreement, according to court documents. During that time, the judge placed Somerlik on probation and ordered her to perform 50 hours of community service.

On May 22, 2007, after successfully completing her probation, the judge dropped the felony charge against Somerlik and ordered her to pay \$8.30

Bedell was fired in retaliation for complaining about abuse and neglect of veterans at the Prescott VA - could take months to complete, depending on the total case load of the individual investigator and the complexity of the allegations.

Meanwhile, Mitchell said, a second case involving disclosures of neglect and abuse that Bedell made in her whistleblower retaliation case is still developing.

"It may be referred to the Secretary of the Department of Veterans' Affairs for investigation," Mitchell said.

"Our first task is to see if we can make a substantial likelihood finding, which means we believe there is a better than even chance that the whistleblower's disclosures are true," Mitchell explained.

Because of the information contained in Bedell's retaliation complaint, the OSC asked her to file a "disclosure" complaint in early June.

Prescott VA's director, Susan Angell, has declined to speak directly to The Daily Courier. But when a staff member to Sen. John McCain asked Angell about some of Bedell's charges, Angell - in a letter that The Daily Courier obtained - said that the Prescott VA fully investigated Bedell's allegations.

"Most of the allegations were unsubstantiated," Angell wrote. "Several allegations were found to be essentially a difference of opinion ... Other allegations were found to be substantiated in part and corrective action was taken."

Bedell denies that her complaints were fully investigated.

The Daily Courier has been looking into Bedell's charges of abuse and neglect at the Prescott VA since June, after learning of Bedell's firing.

During the past three months, The Daily Courier has spoken with four nurses with knowledge of the center's caregiving practices.

The Daily Courier also spoke to more than two dozen patients, family members and other Prescott VA staff.

In addition, The Daily Courier has examined nearly 100 pages of documents, letters and e-mails, including Bedell's federal whistleblower prohibited personnel practice complaint as well as the federal whistleblower "disclosure" document that federal officials asked Bedell to file.

Nurses, veteran patients and relatives of veteran patients at the Prescott VA say some of the nursing staff there - mainly at the center - abuse, neglect and overmedicate patients - actions the nurses say have sometimes lead to injury and in some cases may even have hastened death.

in restitution to the Prescott VA plus pay a \$25 special assessment. The judge did not impose a fine and returned Somerlik's passport.

Somerlik originally was indicted for stealing 166 oxycodone tablets, according to a press release issued on Oct. 20, 2005, by Douglas Carver, who was at that time the special agent in charge of the VA's Office of Inspector General's Western Field Office.

A July 6, 2005, memorandum of commendation to Bedell from Loretta Rizzo - who was the nurse manager of the Community Living Center at the time - said, "You handled a difficult and emotionally complex situation with impeccable care. I appreciate your investigation and that you alerted me in a timely manner of your findings."

The memo went on to say that Bedell's help "allowed NAVAHCS to quickly resolve this issue."

But Bedell says the resolution wasn't all that quick.

"This would never have been caught if I hadn't pestered everyone over and over again that narcotics were being taken," Bedell explained to The Daily Courier.

"No one would believe me because the counts were all correct," she continued. "Unfortunately for the LPN who decided to steal from my med(ications) cart, I had a funny feeling like something was missing, even though the counts were correct.

"I informed the police and my boss, but they wouldn't do anything until I found someone who knew how to run reports and was able to prove it to them. Turned out there was a glitch in the system. To give a narcotic, you had to check it out in the narcotic software, and then in the patient software. The two programs were not connected, and thus it didn't look like anything was

Prescott VA officials say the employees making the complaints are "disgruntled" and that family members are misinterpreting what they see.

The officials say every patient at the Prescott VA gets the same high-quality care and they flatly deny any abuse or retaliation is taking place.

VA CONFIRMS SOME PATIENT CARE PROBLEMS

However, during a recent interview with The Daily Courier, the same officials - Associate Director for Patient Care Services Marianne Locke and the center's medical director, Dr. Jyoti Walavalkar, with Prescott VA spokesman Frank Cimorelli present - confirmed at least some of the accusations.

For example, Bedell in her whistleblower complaint says that a nursing staff member shoved a wheelchair-bound patient's injured foot into a wall so hard that doctors had to reset the pins in the patient's foot.

The term "nursing staff" at the Prescott VA refers to registered nurses, licensed practical nurses and certified nursing assistants.

Two other employees that The Daily Courier interviewed backed up Bedell's charge.

Locke confirmed that the incident took place but said the employee responsible for the incident no longer works there. When told that nurses say the man is still there, Locke said she would find out the man's status and get back to The Daily Courier. But VA officials later declined to comment further about that specific incident.

Officials did say that the Prescott VA takes situations like these "very seriously" and reviews them to assess and fix any personnel and training issues involving patient safety.

Bedell and the other nurses also said three veterans were overmedicated so badly for constipation that they were found laying in liquid pools of their own excrement from their armpits to their knees. Their explosive diarrhea continued until the medicine wore off.

Locke and Walavalkar also confirmed that these incidents took place. They said a pharmacist and several nurses were retrained as a result. They also said that nurses should use their own judgment in determining how much medication to give.

The nurses who spoke with The Daily Courier also said some nursing staff members refuse to help patients.

"We've had issues with (some of the nursing staff) and we've addressed that appropriately," Locke said.

NURSES SAY NEGLECT CONTINUES

But the nurses The Daily Courier has spoken with say problems with patient care continue. They said a few of the nursing staff deliberately treat patients badly while low staffing levels and poor communication among staff members lead to the kind of benign neglect from other staff members that endangers patients.

Examples of their concerns over the past few years - which are also alleged in Bedell's whistleblower complaints - include:

- Patients left sitting in urine and feces for so long that they are found with their private areas sore and

missing. It was a very emotional situation until I could get someone to believe me."

Prescott VA spokeswoman Ame Callahan declined to comment specifically on the case, saying once the case was turned over to the Inspector General, it became a legal process "outside our jurisdiction."

reddened or with crusted urine in their pelvic area.

- Nursing staff who sometimes handle patients roughly and openly mock them.
- Nursing staff who falsify medication and treatment records to show that treatments have been applied to patients or medicine given to them when it hasn't been. This includes charting - verifying that a staff member has completed a patient care task - as long as two days ahead of time.

A Sept. 5, 2007, memo from supervisor Karen Martin to Bedell, which is included in Bedell's whistleblower complaint, asked Bedell to document her witnessing of "staff pre-pouring meds and doing other work-arounds."

"We want this documented so that we may start corrective measures," Martin wrote.

- Patients found with pills scattered in their bed sheets or left laying on their nightstands.
- Missing medications.
- Staff overmedicating patients, sometimes without their knowledge, for the convenience of the staff - a practice known in the medical community as "chemical restraint." In one case such overmedication resulted in a patient's inability to eat or drink because of excessive sedation, Bedell said.
- Too frequent use of foley catheters in patients who don't need or want them, leading to bloody, overflowing catheters that cause infection, pain and needless use of patient restraints. A foley catheter is a thin tube inserted into the bladder to drain urine.
- A nurse who accidentally left a cap on a foley catheter when she inserted it so no urine drained for several hours until the next shift discovered the problem.
- Two nurses who accidentally gave forced air instead of oxygen to a patient who had just returned from surgery.
- A patient who slept on a blanket because his sheets were dirty from not being changed.
- Nursing staff who put patients to bed after dinner without taking their clothes off, who hang up on patients when they put their call lights on and who take excessive time to answer call lights because they are chatting or surfing the Internet.
- A nurse who initially ignored a patient with a painful herpes chest wound saying, "What does it matter. He's dying anyway."
- An Aug. 19, 2007, memo - which also is part of Bedell's whistleblower complaint - to housekeeping supervisor Steven Peterson, complaining about filthy rooms: "I just can't tell you how disgusting some of the patients' rooms are when I come in to work ... especially the floors, sinks, bathrooms, toilets. We find things under the beds that have been there for days. Some of the sinks and mirrors look (like) they haven't been washed in days. The floors are sticky around the patients' beds. Bedside tables are never cleaned except by nursing staff."

Peterson replied in a memo to Bedell the next day that "this will be checked into immediately."

VA officials, in responding to questions about patient care at the center, declined to answer specific questions about employees or patients.

However, Cimorelli explained that when anyone reports an incident, the Prescott VA investigates it thoroughly.

He also said the center's nursing staff "maintains appropriate standards of care."

Locke also said the Prescott VA is not abusing or neglecting patients.

"These things are not happening here," Locke said. "We have people who would like to see us in a bad light."

Cimorelli said that when "adverse" events do happen at the center, staff reviews them carefully so they can learn from them.

He also said all medication errors, including medications not being given to patients, are "tracked and trended" and spot observations of staff passing medications also are conducted.

"Identified concerns are addressed immediately," Cimorelli said, and staff always looks for opportunities for improvement. He said the Prescott VA's medication error rate for the second quarter of fiscal year 2008 was "very low."

DIFFERING VIEWS ON TERMINATION

Bedell's termination notice, signed by Angell and obtained by The Daily Courier, said Bedell was fired "because on several occasions you have removed foley catheters from patients without orders to do so."

However, Locke - an RN herself - 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.

One of the two patients that Bedell removed bloody catheters from wrote a letter to Bedell thanking her for her actions, which the patient says were done at his insistence. The patient's letter is part of Bedell's whistleblower complaint.

But Locke said, "That situation was investigated and found not to be as the nurse described it." Locke declined to elaborate.

Bedell said she carefully monitored both patients after removing their catheters.

She says the last time she removed a catheter was on Jan. 28 and the issue never came up again until she was fired in April - two days after writing a lengthy email to Locke alleging patient mistreatment and that staff often falsifies records.

Prescott VA officials deny that they retaliate against anyone.

One VA employee, who asked that her name not be used, said Angell recently held a staff meeting during which she told employees that if they didn't like the conditions at the Prescott VA, they should leave.

Cimorelli said Angell often meets with groups of employees.

"One of the areas she discusses is the privilege of serving veterans," Cimorelli wrote in an email. "This privilege requires a high degree of commitment and compassion by employees. If this level of expectation is not comfortable for an employee, she asks them to think about making choices that fit their own individual needs."

STAFFING SHORTAGE

Many of the center's problems stem from an overworked and exhausted staff pushed to the limit by too many patients with increasingly serious health issues, the nurses told The Daily Courier.

They say morale at the center has plummeted, turnover has risen, and a tense climate of fear has taken hold.

Locke agrees that the center is struggling with a serious nursing staff shortage. An internal VA management memo that The Daily Courier obtained called the shortage a "crisis."

Locke said that between the center and the acute care facility, which is in a different building, 10 nursing staff positions are unfilled.

She says they are working to fill the shortage by hiring temporary nurses and by asking staff to work overtime as well as by not operating at full capacity. The center has a total of 85 beds, Locke said, but fills only 60 to 65 beds.

Locke said the center typically has one nurse - either a registered nurse or a licensed practical nurse - and one to two certified nursing assistants on each of five wings. But, Locke said, sometimes supervisors have to send even those nurses and CNAs elsewhere to help out.

A memo, entitled "Staffing Issues and Patient Safety" that Locke sent to staff this past spring said officials had decided to divert admissions to the center as much as possible and to share staffing between units.

"But this is not reliable, as all units are experiencing staffing issues...," Locke wrote.

NOT OUR FIRST RODEO

Cimorelli, the Prescott VA's spokesman, said the Prescott VA would weather any investigation that any reports of abuse may prompt.

"This isn't our first rodeo," Cimorelli said. "We know what it is to deal with Congressionals," he continued, referring to members of Congress.

Prescott VA director Angell does, too.

She was the associate director at Bay Pines VA Medical Center in Florida in 2004 when several Congressional committees and the VA Inspector General's office conducted investigations there.

That round of investigations turned up mismanagement by senior staff at Bay Pines and lead to an upper management shake-up there.

Before the VA Inspector General's investigation of Bay Pines concluded, Angell volunteered for a temporary assignment in Afghanistan.

According to the Aug. 11, 2004, final report on Bay Pines by the Office of Inspector General, "In many areas of (the facility), a culture of safety and accountability was not evident. Communication that was important for patient safety was not discussed out of fear of adverse consequences."

The report also said that, "Senior leadership needed to better manage and administer facility operations ... Factors such as ... employee mistrust in leadership's ability to manage and treat them fairly, morale challenges, and a growing workload demand generated by a rapidly expanding veteran community contributed to lapses in providing timely care and ensuring administrative accountability."

The report about Bay Pines, where Angell was second in command, stressed that, "One important tenet of a

culture of safety is the ability for an employee at any level to feel empowered to express a view against the authority gradient without fear of adverse consequences." The Bay Pines report did not specifically name Angell although it did refer to an interview officials had with the associate director.

The Prescott VA employees who The Daily Courier spoke with say the same mismanagement that investigators found at Bay Pines is happening in Prescott.

Mary Garrison, president of the American Federation of Government Employees Local 2401 at the Prescott VA, says management there wouldn't have so many problems if it would accept responsibility for its poor supervisors.

"They don't even want (people to file) reports," Garrison said. "And they badger the employees that (do) file the complaints."

She says most employees with complaints simply give up after awhile.

Many of the people The Daily Courier spoke with for this article said the Prescott VA has plenty of good employees. But there are problems, they say, and the VA needs to fix them.

"There are good staff there and basically the care is good," Bedell told The Daily Courier. "The staff that are bad are few in number; the staff that are overworked and stressed are many and (they are) making mistakes."

VA spokesman Cimorelli said the Prescott VA would deal with any problems it has.

"If there's problems here, then we are going to address it," Cimorelli said. "If there's sensitivity issues, then we're going to address that, too."

Contact the reporter at tshultz@prescottaz.com

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