

**5 USC § 1213 (a) (1)(A) (B)**

Sec. 1213. Provisions relating to disclosures of violations of law, gross mismanagement, and certain other matter (a) This section applies with respect to – (1) any disclosure of information by an employee, former employee, or applicant for employment which the employee, former employee, or applicant reasonably believes evidences – (A) a violation of any law, rule, or regulation; or (B) gross mismanagement, a gross waste of funds, an abuse of authority, or a substantial and specific danger to public health or safety;

**ISSUE I NOT QUALIFIED INDIVIDUAL FOR POSITION; NOT QUALIFIED TO PERFORM ADVANCED CLINICAL FUNCTIONS OF COMMUNITY HEALTH NURSE****Federal Office Personnel Management OPM Standards**

OPM Qualification Standard for General Schedule Position Nurse Series, 0610. There is no Group Coverage Qualification for this series. Use the Individual Occupational Requirements described below. **Position Education Basic Requirements CHN at GS 5 and above must have graduated from a baccalaureate or higher degree nursing program.**

**AR 40-48**

Nurse Practitioners, Certified Nurse Midwives, Community Health Nurses, and Certified Registered Nurse Anesthetists

**2-1. Privileges**

Prior to applying for clinical privileges, each nurse practitioner (NP), certified nurse midwife (CNM), **community health nurse (CHN)**, and certified registered nurse anesthetist (CRNA) will **meet the criteria for his/her clinical specialty as listed by definition in Section II, Terms**. The policies and procedures for credentials review and clinical privileging will be consistent with **AR 40-68**. The individual's completed application and practitioner credentials file

**AR 40-48**

Page 20 Terms and Conditions

**Community health nurse**

A registered nurse who has successfully completed a post baccalaureate program of study (for example, Principles of Military Preventive Medicine 6A-F5) which prepares the registered nurse to provide family-centered nursing services to individuals, families, and groups in the community which include epidemiological and health promotion support.

**AR 40-68****7-4 a (2)**

Advanced Practice Nurse Description

**(2) Community health nurses (CHNs)** function in an expanded role using CPGs approved by the ECMS and the DCN. In this role, the CHN may **refill** prescriptions, or perform other clinical functions of a more complex nature, but he/she does not independently initiate, alter, or discontinue any medical treatment. Likewise, the scope of practice of occupational health nurses (OHNs) typically includes CPG or protocol-based patient interventions. In selected circumstances, either the CHN or OHN may be assigned duties or functions for which clinical privileges are deemed appropriate. **CHNs and OHNs who meet the criteria as an APRN may be granted clinical privileges as approved by the MTF commander.**

**AR 40-68**

**3-3 Performance improvement data sources and analyses**

*b.* Various activities, programs, and processes such as those in (1) through (7), below, merit consideration as sources

of information that may influence the PI Program within the organization.

(7) or other nursing specialty **American Nurses Association (ANA) Standards of Nursing Practice** organization's standards of practice (for example, the Association of peri Operative Registered Nurses or the American Association of Critical Care Nursing, as appropriate) for the delivery of nursing care and recognized practice standards for other healthcare specialties.

## ANALYSIS

**TAB N-18** of Army Investigative Report (**AIR**) contains resume of X .

**TAB M-1of AIR** contains the 2009 **Vacancy Announcement SCEG9508786**; for the position of Community Health Nurse (CHN) OPM Series 0610, Lyster Army Health Clinic (LAHC) to which X applied. The resume:

Does not contain experience of medical management of clinical programs for Public Health

Does not note a Public Health Nurse credential/certificate

Does not note a Bachelor of Science of Nursing (BSN)

**Notes an Associate's Degree of Nursing (ADN)**

Does not note a an Advanced Practice Community/Public Health Practitioner license

Contains a month of clinical experience in 2007 in Russia as a nurse/monitor

Notes most recent **clinical nursing experience in 2005**: direct temporary patient care operating room, emergency room, radiology and cardiac cath labs, **not public health**

Rather, the resume reflects that **analyzed Public Health Grant Programs** at the Federal Grant Agency, Health Human Services (HHS), Health Resource Service Agency (HRSA), Red Cross experience was to conduct a survey of shelters to improve performance of care , rewrite a mold safety, compile a listing of medical care and provide mental health counseling and debriefing after National Disasters. The National Disaster Medical System, Disaster Medical Assistance Team (DMAT) experience states that X provided medical assistance to fire fighters and was deployed in a standby position and for the first Orange Alert (which was a standby for 10 days)- title in the GS system is Nurse Supervisor (for pay reasons). The Health Emergencies Large Population training at Johns Hopkins University states training for **refugee disaster population health emergencies**.

**TAB M-1 of AIR**, Vacancy announcement SCEG9508786 lists the functions of **coordination, planning, implementing and evaluating health education classes, encouraging behavioral changes and assisting with epidemiological investigations of HIV patients. Assist** in coordination and implementation of comprehensive CHN program, **participates** in operation of TB control program and **conducts health education activities which revolve around group interaction**. There was experience noted on the resume for planning, implementing and evaluating programs, mental health crisis counseling, and training of groups. X had skills to perform crisis intervention with patients and families, some basic knowledge of public health programs, experience with educating patients and coordinating, planning and implementing programs; so X applied to the vacancy. One year after applying the Army called and interviewed her for the position.

**TAB M of AIR, pg. 1 answers 3 and 4** X did not misrepresent her credentials, license, experience or training in the telephone interview with Major Ricardo, Master Science Nursing, Chief Preventive Medicine, LT COL W. Campbell, Advanced Practice Nurse Practitioner, Director Nursing Command, B. Downing ,CHN, Doctorate Science Nursing (DSN) and COL Parsons, Registered Nurse, Registered Pharmacist, Chief of Pharmacy.

**TAB N of AIR, page 2 answers 8 and 9.** Major Ricardo states 'She impressed the interview panel with having researched our organization (LACH) prior to the interview which indicated she was a higher caliber candidate because most interviewees would not go to such lengths' and answered "no" that X did not misrepresent qualifications.

**TAB Q of AIR, pg. 3, 1 Paul Macias, Chief Policy and Programs Branch, Civilian Human Resources Division Headquarters, U.S. Army Medical Command stated in his declaration, 'OPM Position Classification Standard is used to assign the proper occupational series title', but neglected to state that OPM education requirements for CHN 0610 at GS 5 and above was a baccalaureate degree or higher in nursing- Exhibit A -5, A-6**

**TAB H OF AIR , AR 40-68 7-4 a (2) page 27 states Advanced Practice Nurse Description (2) Community health nurses (CHNs) function in an expanded role using CPGs approved by the ECMS and the DCN. In this role, the CHN may refill prescriptions, or perform other clinical functions of a more complex nature, but he/she does not independently initiate, alter, or discontinue any medical treatment. Likewise, the scope of practice of occupational health nurses (OHNs) typically includes CPG or protocol-based patient interventions. In selected circumstances, either the CHN or OHN may be assigned duties or functions for which clinical privileges are deemed appropriate. CHNs and OHNs who meet the criteria as an APRN may be granted clinical privileges as approved by the MTF commander.**

**TAB H of AIR page 9, AR 40-68 3-3 b. (7) Performance improvement data sources and analyses states the Army uses the standards of the American Association of Nurses and other healthcare specialties as a standard of practice.**

**Exhibits A 8- A-10The ANA in 2007 recognized two levels of public health nurses, one a generalist prepared at the baccalaureate level of education and a specialist prepared at the graduate Master degree level of nursing. The Association of Community Health Nursing defines baccalaureate degree as minimum requirement for entry level professional Community/Public Health Nurse. Army Public Health Nursing announcement "after you obtain your Bachelor of Science in Nursing , you will need to attend the Army Occupation Code (66B) Producing Course and the Principles of Military Preventive Medicine Course (6A-F5).**

**TAB A of AIR page 9, footnote 8 Col D. Lounsbury, Chief of Army MEDCOM Quality Management Division headquarters stated 'that placement of CHNs under the description of Advance Practice Nurses is inaccurate and confusing' and added upon the next revision of AR 40-68, it would be corrected. CHN was located as an Advanced Practice Nurse Description when X applied to Vacancy announcement SCEG9508786 in 2009 and was hired for this vacancy announcement in 2010.**

**Exhibit A-7 Vacancy Announcement MD DHL-12-4031 Date: 02/2012 LACH advertisement for CHN with education requirements Bachelor degree Nursing. This is evidence that although the report states X was qualified with an Associate Nursing Degree, when the Vacancy Announcement to replace X was written; it stated the required education was a Bachelor in Nursing.**

#### **EXHIBITS A 1-10**

**A-1 AR 40-68 2-1 Privileges**

**A-2 AR 40-68 2-1 cont.**

**A-3 AR 40-68 2-2 Expanded Roles/2-3Supervisory Personnel**

**A-4 AR 40-68 pg. 20 Terms and Conditions**

**A-5 Nurse Series, 0610 Basic Requirements**

**A-6 Continuation of Nurse Series 0610 with specific education requirements for CHN GS-5 and higher graduation from a baccalaureate or higher degree nursing program**

**A-7 Vacancy Announcement MD DHL-12-4031 Date: 02/2012 LACH advertisement for CHN with education requirements Bachelor degree Nursing**

- A-8. American Nursing Association definition of two levels of public health nurses and the education requirement  
 A-9 Association of Community Health Nursing defining baccalaureate degree as minimum requirement for entry level professional Community/Public Health Nurse.  
 A-10 Army Public Health Nursing announcement 'a Bachelor of Science in Nursing is needed to attend the Preventive Medicine Course to become an Army Public Health Nurse'

## CONCLUSION

According to the above Laws, OPM Standards of Education Nurse Series 0610, Army Regulations and ANA Standards of Practice, **X was not qualified to be a Community Health Nurse**; as she lacked the requisite minimal education of Bachelor of Science Nursing (AR 40-68) (OPM)(ANA)(ACHNE). X was chosen because she researched the LACH Preventive Medicine Department and had 37 years of nursing experience (according to testimony of Major Ricardo). The Army report failed to recognize that X had not performed clinical nursing duties for 5 years and had worked as an analyst of Public Health grant, not as a Public Health Nurse. When Lyster Army Health Clinic advertised the CHN position after terminating X; the education requirement was Bachelor of Nursing. **X was not qualified to be a CHN. The Army Investigative report argument that X was qualified is not valid. The Army was negligent in not following the Office of Personnel standards for education of CHN and their own regulation AR 40-68 2-1, Terms and conditions page 20.**

## ISSUE II X NOT GIVEN A STRUCTURED ON THE JOB TRAINING, X NOT DESIGNATED PHYSICIAN SUPERVISION DURING CLINICAL PRACTICE, DUTIES NOT IN X SCOPE OF PRACTICE

### AR 40-48

Nurse Practitioners, Certified Nurse Midwives, Community Health Nurses, and Certified Registered Nurse Anesthetists

#### 2-1. Privileges

Prior to applying for clinical privileges, each nurse practitioner (NP), certified nurse midwife (CNM), **community health nurse (CHN)**, and certified registered nurse anesthetist (CRNA) **will meet the criteria for his/her clinical specialty as listed by definition in Section II, Terms.**

*c. Community health nurse.* The CHN and the designated physician supervisor will establish mutually agreed upon practice protocols/CPGs. These practice protocols/CPGs will be signed by the supervising physician, the individual CHN, the chiefs of community health nursing and preventive medicine, and the CN. Drugs approved for prescription writing will be included as part of the recommended clinical privileges. Practice protocols/CPGs will be reviewed annually and updated as necessary.

### AR 40-48

#### 2-2. Expanded roles

Army Nurse Corps (AN) officers and **civilian registered nurses who function in expanded roles** and clinical specialty areas (for example, NPs, CNMs, or CHNs) **must be prepared through relevant education and experience.** Their performance will be routinely evaluated to document current competence and identify the knowledge, skills, and behaviors needed to maintain and improve the care provided.

*a. Prescription writing.* Those nurses who are privileged may write prescriptions for selected medications that have been recommended by the pharmacy and therapeutics (P&T) committee, reviewed by the credentials committee, and approved by the MTF commander. (See AR 40-2 for information on the establishment, composition, and functions of the P&T committee.) **All prescriptions will bear the typed, stamped, or printed**

statement: "May be filled at any military health services system (MHSS) pharmacy that recognizes the provider's privileges."

#### AR 40-48

##### 2-3. Supervisory personnel

**b. Community health nurse.** CHNs assigned to a U.S. Army Medical Department Activity (MEDDAC) or U.S. Army Medical Center (MEDCEN) preventive medicine service are responsible to the chief, community health nursing service and chief, preventive medicine service. The chief, community health nursing service is responsible to the CN for administrative matters and professional nursing concerns. **Medical supervision and direction will be provided by an appointed physician supervisor. A CHN who provides care to several defined patient populations may have more than one appointed physician supervisor.** The specific medical supervisors will be dictated by the specialty of the patient population involved (for example, chief, pediatric service for well child physical assessment; chief, pulmonary disease service or appropriate medical specialty for the Tuberculosis Chemoprophylaxis Program).

**c. Physician supervisor.** The MTF commander will appoint (by name and in writing) a supervising physician for each NP, CNM, and CHN. An alternate supervising physician must be available during temporary absences of the supervising physician. The supervisor must be available for consultation in person or telephonically. **The MTF commander will ensure the effectiveness of the supervision and review process.**

(1) **Qualifications and duties.** The physician supervisor will—

(a) Be privileged to perform any treatment or procedure that he or she directs a nonphysician HCP to perform.

(c) Ensure the care provided by the NPs, CNMs, CHNs, and CRNAs remains consistent with their respective scopes of practice and, for NPs, CNMs, and CHNs, within their approved protocols/CPGs.

(2) **Performance evaluations.** The supervising physician may provide written performance evaluations using the DA Form 5441-R series (Evaluation of Privileges—(Specialty)) and DA Form 5374-R (Performance Assessment) that document current competence of the individual's—

(a) Diagnostic techniques and procedures.

(b) Therapeutic practices/process of care.

(c) Patient treatment documentation based on a review of patient records. The number of records to be reviewed will be determined by the supervising physician based on (a) and (b) above and the quality of the entries.

(3) **Frequency of performance evaluations.** The supervising physician ensures that—

(a) Performance evaluations are conducted periodically based on the individual's experience and competence and according to local quality improvement (QI) policy and AR 40-68.

(c) A copy of all written performance evaluations (with the exception of DA Form 67-9 (Officer Evaluation Report)) is forwarded to the MTF credentials committee. These documents will be maintained according to AR 40-68 and will be part of the basis for renewing/revising clinical privileges.

#### AR 40-68

##### 5-2. Delegation

**a.** Delegation transfers to a competent individual the authority to perform a selected patient care task in a given situation. Typically, delegation involves the licensed or privileged professional allowing a specified patient care activity; that is within his/her own scope of practice, to be performed by unlicensed assistive personnel (UAPs), an RN/LPN, or other nonnursing personnel. **The authority to perform the task is passed to another but the professional responsibility and accountability for the overall care provided, and for associated patient outcomes, remains with the delegating individual.**

*Note.* In structured training situations, a provider may delegate a privileged task, function, or process to a competent nonprivileged professional (for example, a medical student, or 18D. The privileged provider is responsible and accountable for

the task, function, or process that has been delegated, and for the patient outcomes. A specific, written plan for supervision of the nonprivileged individual, as determined by the assessed level of his/her competence, is required. (See para 5-3 for additional detail regarding types of supervision.)

**AR 40-68****5-3. Supervision of practice**

(2) **In select circumstances** (that is, for professionals not yet licensed, for novices or those returning to patient care responsibilities who must develop/refine skill and competence, or for those staff whose performance is less than acceptable) supervision is a formal requirement. The type of supervision that is warranted will be clearly identified and the plan for supervision articulated in writing.

*c. The plan of supervision.* The intent of providing appropriate oversight of practice, in the context of this regulation, is to evaluate and enhance performance of health care personnel in delivering patient care services. Given that objective, a **planned and organized approach to supervision is appropriate. The written plan of supervision, maintained in the PAF (privilege-eligible provider) or CAF (nonprivileged professional), as appropriate, will include—**

- (1) **The type of supervision to be provided.** (See para *b* above.) The type of supervision will be based upon the assessed needs of individually privileged providers/nonprivileged personnel.
- (2) **The name of the supervisor.** The commander will appoint—in writing—a primary and alternate supervisor.
- (3) **Performance evaluations.** The specific intervals at which performance evaluations will be conducted during the period of supervision will be noted.

**AR 40-68****7-2. Clinical practice**

*a. Decision making.* Clinical care decisions and specific therapeutic interventions on the part of the provider are based, in part, on CPGs; nationally recognized standards of care/practice; current professional clinical references; and other relevant regimens, guidelines, or policies, as appropriate. These serve as a framework for practice and are the basis for the specific clinical privileges requested by the individual provider and for periodic performance review and evaluation activities.

*c. Pharmaceuticals.* **Privileged providers are authorized to prescribe pharmaceuticals** contained in the MTF formulary according to the guidance established by the local P&T committee. **For providers other than physicians and dentists, the drugs approved for prescription writing will be based on the provider's scope of practice and the beneficiary group(s) served.** An open formulary is authorized. Facility-specific exceptions, either by category of drug or itemized by name of drug, will be noted in writing. Prescription writing authorization—as recommended by the P&T committee, reviewed by the credentials committee, and approved by the MTF commander—will be annotated in the PCF as an addendum to the provider's delineation of clinical privileges.

**AR 40-68****7-4. Advanced practice registered nurse****a. Description.**

(2) Community health nurses (CHNs) function in an expanded role using CPGs approved by the ECMS and the DCN. In this role, the CHN may **refill** prescriptions, or perform other clinical functions of a more complex nature, but he/she does not independently initiate, alter, or discontinue any medical treatment. Likewise, the scope of practice of occupational health nurses (OHNs) typically includes CPG or protocol-based patient interventions. In selected circumstances, either the CHN or OHN may be assigned duties or functions for which clinical privileges are deemed appropriate. **CHNs and OHNs who meet the criteria as an APRN may be granted clinical privileges as approved by the MTF commander.**

**c. Scope of practice**

**(1) The APRN is a licensed and privileged practitioner and, as such, co-signature by a physician or other privileged provider of APRN entries in the patient's medical record, prescriptions, and so forth, is not required.**

**AR 40-68****2-3. Military treatment facility departmental structure and leadership**

The bylaws will describe the qualifications, roles, and responsibilities of department chiefs.

**a. Physicians or other privileged providers will be appointed as chiefs of medical departments/services by the commander. Selection will be based on qualifications including clinical and leadership experience and ability. In instances where a non-physician serves as the chief of a department/service, a physician will be selected as the medical director. The medical director will advise the chief and be responsible for practice issues outside the clinical scope of the non-physician chief. The medical director will be responsible for peer review and the credentialing and privileging of physicians and other privileged providers. The chief will represent the department/service at the ECMS and other required meetings.**

**AR 40-68****5-2. Delegation**

**a. Delegation transfers to a competent individual the authority to perform a selected patient care task in a given situation. Typically, delegation involves the licensed or privileged professional allowing a specified patient care activity, that is within his/her own scope of practice, to be performed by unlicensed assistive personnel (UAPs), an RN/LPN, or other nonnursing personnel. The authority to perform the task is passed to another but the professional responsibility and accountability for the overall care provided, and for associated patient outcomes, remains with the delegating individual.**

*Note. In structured training situations, a provider may delegate a privileged task, function, or process to a competent nonprivileged professional (for example, a medical student, or 18D. The privileged provider is responsible and accountable for the task, function, or process that has been delegated, and for the patient outcomes. A specific, written plan for supervision of the nonprivileged individual, as determined by the assessed level of his/her competence, is required. (See para 5-3 for additional detail regarding types of supervision.)*

**AR 40-68****2-4. Executive committee of the medical staff**

The ECMS is authorized to carry out **medical staff responsibilities** and performs its work within the context of the functions of governance, leadership, and PI. The ECMS has the primary authority for activities related to self governance of the medical staff and for PI of the professional services provided by privileged healthcare providers.

This committee reports to the executive committee. Note: There is currently no requirement for an executive committee of the dental staff (ECDS). Where this regulation requires information/action to route through the ECMS to the commander, it may go directly to the dental commander.

**a.** The majority (at least 51 percent) of voting ECMS members will be **licensed physicians with current privileges** and medical staff appointments.

**b.** Voting membership will include the DCCS (chairperson), the DCN, and chiefs of clinical departments. Other

**c.** The ECMS functions may be conducted by the entire medical staff (committee of the whole) concurrently with those of another MTF committee (for example, the credentials committee) or by a separate committee.

**d.** The ECMS acts upon reports of NTF committees/functions clinical departments and subcommittees or workgroups designated by the ECMS. In addition, this committee provides recommendations to the commander at a minimum on the following:

(1) The medical staff structure.

**(2) The process for credentials review and delineation of individual clinical privileges.**

(3) Medical staff membership and termination of membership.

(4) The delineation of privileges for each eligible provider. (If the ECMS and the credentials committee are not the same body, the privileging recommendations of the credentials committee for each provider will be reviewed by the ECMS and forwarded to the commander.)

(5) The mechanism for terminating medical/dental staff membership.

(6) The mechanism for adverse actions fair hearing and appeal procedures.

**(7) The participation of the medical staff in organizational PI activities.**

## ANALYSIS

X was not qualified to be practicing as a community/ public health nurse because she lacked the formal baccalaureate or higher education and public health training as noted in Issue I.

**TAB N-5 TAB N-6 of AIR** X gave Downing X's calendar training dates, Downing initialed them on the orientation sheet on October 6<sup>th</sup> the day after the counseling meeting. Downing told X that Major Ricardo could do the competency markings as she (Downing) was asked to orientate. X gave the sheet to MAJ Ricardo- who never checked on X being competent.

**TAB A pg. 26 of AIR** X wrote notes step by step. The calendar notes many activities on these days of training X had Ft. Rucker training ,AHLTA-training (from non medical trainer) and brief bits of training from Downing

**TAB N-5 and N-6 of AIR.** There was no formal plan of training; it was varied and X wrote down what she learned every day on a calendar for Major Ricardo as she requested.

**TAB A pg. 20 of AIR** statement of Dr Gilbert that X asked if he would show her how to do the assessments and she could gain working experience.

**TAB A pg. 20 of AIR** Dr Gilbert notes that he told Major Ricardo that X was experiencing difficulties as a CHN.

**TAB G pg. 2 of AIR** Organizational structure of the Preventive medicine clinic with no names - no physician noted on the chart as Chief medical director who should have been over the CHN (according to the above Army regulations).

**TAB N-5 of AIR, TAB N-6 of AIR** are calendar that X hand wrote and the form that orientation was given should not in any means be construed as a formal training such as the Army gives its Public Health nurses who function in the same capacity as CHNs on many Army bases.

**TAB A of AIR , pg 28** states Although their are training programs provided by the U.S. Army MEDCOM for Army Nurse officers, on the job (OJT) is the primary means of training public health nurses such as Ms X.

**TAB A of AIR pg. 25** states in the duties of a CHN at LAHC that investigation of communicable diseases, HIV, STD, Tuberculosis Control program, counseling for life style health risk, child and youth services consultant, special needs resource team and conduction of monthly inspections of CYS.

**TAB A of AIR pg 38 no. 6** states the investigative officer found that the Preventive Medicine Clinic at LAHC had a structured orientation and training program for CHNs.

**TAB N-4 September 17 was the first face to face counseling session of expectations of X.** October 4, X talked with Major Ricardo stating she was not being adequately trained and was in a hostile environment. Major Ricardo held a meeting and gave **Exhibit B-1, X counseling letter** and a different counseling letter to B. Downing (which was not part of the record in AIR) as to training expectations. X again wrote a letter to Major Ricardo on October 11<sup>th</sup> **Exhibit B-2** that stated she was not being trained and was being trained in a hostile environment.

**TAB A of AIR pg 36 paragraph 3 Ms X was not privileged (provider)**

**TAB A of AIR pg 20, paragraph 2** Dr. Gilbert states that it was becoming too time consuming and it might be easier to do the initial evaluations by himself. Major Ricardo state she would work with X and subsequently X no longer asked him to assist with initial interviews.

**TAB A of AIR pg 39, paragraph 1** Investigative officer states due to unpredictability, of opportunities to perform certain tasks, there was no hard date to complete this assessment; however the normal standard for completions was within 2-6 months of employment

**Exhibit A-10** Army training course

**Exhibit B-12** DA Form 5441-47 Preventive Medicine Evaluation of Clinical Skills

**Exhibit B4** The copy of the prescription bottle is **not a refill** and the pharmacist filled it with **X name as provider**. X was not a **provider or privileged**. The medication was marked with 0 of 0 refills; no matter if it was the first or last bottle of INH, as the patients were required to visit the CHN each month for a new prescription. X's name was in the electronic health record as a Provider (APRN CHN privileges) and that is why her name was on the medication . **X was prescribing the medication each month not a filling a refill of INH.**

Army Nurse Corps Officers must take a Public Health Nursing training in the course Army Occupation code (66B) Producing course and the principles of Military Preventive medicine Course (6A-F5) prior to their public health duties in the same position as Army civilian CHNs, yet on the job training is what the Army investigative officer stated the CHNs receive. Do they not want everyone trained with the same level of knowledge?

The investigative officer stated that the Preventive Medicine Clinic Clinic at LAHC had a structured orientation and training program for CHNs, yet **failed to provide any documentation of the orientation and training other than X had provided on a calendar that X wrote what she learned every day.** Training of CHN duties was not adequate or structured. The list of duties of a LAHC nurse by B Downing were extensive and yet the AI report did

not have any documentation of a structured training program, only B Downing signing off on a sheet that came from another Army base that she orientated X. **Structured training for a CHN and also for a nurse who had not practiced clinical nursing for 5 years simply did not exist.** X's hand written calendar notations cannot in anyway be construed as structured training program. **Several statements by Dr. Gilbert in the above analysis section state that X came to him for help in learning her job with TB patients, then it became too time consuming and it would be easier to do it by himself; yet the Investigative Officer states it was a structured training.** The investigative officer states that the opportunities to perform certain tasks was unpredictable and that is why it was difficult to complete the competency of skills of X. This lack of opportunities is noted on the training calendar ; it was an orientation not a training sheet and an equal level CHN that marked off the orientation sheet as having orientated X not a physician as required. **Dr. Gilbert according to the AR 40-48 2-1 c. and AR 40-68 5-2 a. as X was a non privileged provider was to be supervising (training ) and evaluating X skills Exhibit B-12, not B. Downing or Major Ricardo. DA Form 5441-47 should have been used by Dr. Gilbert to evaluate X's clinical skills.**

X was listed in the electronic health record, CHCS and AHLTA as a Provider; she could not choose a provider for prescriptions (so that they were in fact refills of a provider physician) or labs and tests to be co-signed; (per AR 40-68 7-4 c (1). X as non -APRN, without provider privileges, would need computer orders co-signed by a supervising physician. X was in fact performing as a privileged provider for which she had no formal post graduate training or license. When Dr Gilbert was training X; he told X to order initial medication for Latent TB patients. X informed her supervisor, Major Ricardo and Dr. Gilbert, the physician she was not qualified to prescribe medication and there needed to be updated specific SOPs; as she would not order the initial prescription for INH, she was not qualified.

The Army regulations are very specific in AR 40-68 as to the CHN being supervised by a physician. AR 40-68 a.(2) and AR 40-68 7-4 c (1) state that if the CHN is also an APRN they do not need a physician co-signer-this is interpreted that the non APRN CHN does need a physician co-signer for medication , lab orders and charts in the electronic medical record. AR 40-68 2-3 c (2)notes DA Form 5441-7 is to be used by the physician supervisor to evaluate the skills of the CHN after a planned and organized orientation -not the Orientation form marked by Downing , CHN ,DSN. X had very little training and had to tell Major Ricardo she was receiving inadequate training in a hostile environment as noted by exhibit B.

The Army did not furnish a credentialing committee report allowing X privileged provider status in AHLTA. Nor did they furnish a P&T meeting with a written document of privileges to write prescriptions being granted. Dr. Gilbert was not on a written plan as X's physician supervisor of record and should have been co-signing her charts as X was not an APRN. All of the above were required by Army regulations in this section of Issue II.

## CONCLUSION

X was not afforded a structured on the job training, X did not have a written designated physician responsible for her clinical practice and X's duties were clearly out of her scope of practice as she was not a Provider and was allowed Provider privileges in the electronic health record ;signing her own charts, prescribing medication, ordering her own labs (labs results were returned to her instead of the patient's provider). **The Lyster Army Health Center Medical Command staff is negligent for their actions of not providing the proper training , not designating a physician supervisor of clinical practice, allowing her privileges of a Provider in the electronic health record system and is in violation of Army regulations.**

### ISSUE III NOTIFICATION OF SUPERVISOR AND COMMAND MEDICAL STAFF OF UNSAFE MEDICAL PRACTICES

#### AR 40-68

##### 1-4. Responsibilities

**i (2) Deputy commander for nursing (DCN) (or comparable title). The DCN is/will—**

- (a)* A licensed professional registered nurse.
- (b)* The principal executive staff advisor to the commander on matters concerning the scope of patient care services and clinical policy (specifically related to the provision of nursing care and services and nurse staffing standards), nursing policy, and the availability and utilization of nursing resources.
- (c)* Act as liaison between members of the nursing staff and the commander and, as such, advocate for the provision of quality nursing care, treatment, and services.
- (d)* Participate in the development, implementation, and integration into the organization's overall plan for patient care, policies and procedures that guide and support the provision of quality patient care services.
- (e)* A voting member of the ECMS (or comparably named committee).
- (f)* Ensure PI activities are in place in all and actively participate in these processes. Areas in which nursing care, treatment, or services are rendered
- (g)* A voting member of the MTF credentials committee with responsibility for review and concurrence with scope of practice and privileges for nursing personnel.
- (h)* Reduce or appropriately limit the scope of practice of any nursing staff member whose competence, quality of care, behavior/conduct threatens the health or safety of any patient, employee, or other individual until the matter is investigated and resolved according to the provisions outlined in this regulation. (See chap 9.)
- (i)* Support and actively engage in an ongoing, proactive program for identifying PS risks and for reducing nursing/healthcare errors according to DOD 6025.13-R and USAMEDCOM guidance.

#### AR 40-68

##### 10-2. Command responsibility

**a. Action taken on the part of the commander against a provider's privileges (professional's scope of practice) may be warranted based on performance suspected or deemed not to be in the best interest of quality patient care. These actions include holding in abeyance, denying, suspending, restricting, reducing, or revoking clinical privileges/practice.**

The action taken may be immediate (summary) in the event of a critical incident or as a result of the credential committee's deliberation (routine) on information made available through CQM reporting channels.

**b. The commander's prerogative to hold in abeyance, to deny, or to summarily suspend clinical privileges/practice is exercised when there is reasonable cause to doubt the individual's competence to practice or for any other cause affecting the safety of patients or others. Reasonable cause includes—**

- (2) A pattern of inappropriate prescribing.**

#### AR 40-3

##### 11-2. Responsibilities

**a. The MTF commander, who also routinely serves as the Army installation (in garrison) Director of Health Services, will operate the pharmacy and all aspects of medication management and appropriate and safe drug therapy and will exercise careful supervision over all phases of pharmacy operations and medication management throughout the command. This includes employment of recognized professional procedures and establishment and aggressive pursuit of those policies that ensure conformity with the highest standards of the pharmaceutical profession. The commander will ensure that—**

- (1) Supervision is exercised directly by—**

(a) A pharmacy officer or civilian pharmacist who is a graduate of a recognized school or college of pharmacy and licensed to practice pharmacy in one of the States of the United States, Puerto Rico, or the District of Columbia.

(2) Policies will be established to ensure—

(e) Adherence to appropriate credentialing and privileging procedures, guidelines, and mandates according to Federal law, ARs, DODDs and/or Department of Defense Instructions (DODIs), an accrediting body (for example, TJC

or other), and other regulatory agency requirements for dispensing medication.

b. The Chief, Pharmacy Services (note: exact title of the chief of pharmacy varies depending on local designation) will be charged with the duties of recognizing, identifying, selecting, ordering, preparing, safeguarding, evaluating, and dispensing all pharmaceutical substances (of whatever kind and combination) used in preventive, curative, and diagnostic medicine. The chief and his/her staff will be responsible for keeping abreast of new developments in the field of pharmacy and for operating the pharmacy in compliance with Federal laws, accreditation standards defined by the current accrediting body (for example, TJC or other), and standards of pharmaceutical care within the community.

In doing so, the chief will—

(1) Assist and advise health care providers in the writing of prescriptions, medication orders, and other matters involving the use or misuse of medications.

#### AR 40-3

11-7. Pharmacy and therapeutics committee

a. *Establishment.* The MTF commander will appoint the P&T committee.

b. *Composition.* The committee will include a mixture of clinical and administrative staff so that all specialties are represented to the maximum extent possible.

c. *Objective.* The primary objectives of the P&T committee are—

(1) *Advisory.* The committee recommends the adoption of and assists in the formulation of broad professional policies regarding the Medication Management System to include evaluation, selection, procurement, distribution, use, safe practices, and other matters related to therapeutic agents.

#### AR 40-3

11-9 Performance improvement

a. *Performance improvement process.* The Chief, Pharmacy Services will implement an internal process that will demonstrate improvement in pharmacy services. This process will be integrated with the MTF's organizational performance improvement structure and documentation will provide evidence of ongoing improvement according to AR 40-68.

b. *Recording and reporting medication errors.* The recording and analysis of all MTF adverse events/medication errors will be according to AR 40-68 and current USAMEDCOM guidance and will utilize the standardized/automated DOD medication error reporting system (for example, MedMARx or other).

(1) The implementation of medication error documentation (for example, MedMARx) will be accomplished through a multi-disciplinary approach. The patient safety manager and the chief pharmacist will work together to assume leadership and coordination of the local program.

(4) A root cause analysis, in accordance with the Patient Safety Program, USAMEDCOM, and current accrediting body's (for example, TJC or other) standards, will be conducted on any error in categories G through I and as deemed appropriate by the specific MTF.

(5) Copies of the form may be provided to individuals, services, or departments deemed appropriate to clarify and rectify the problem according to AR 40-68.

#### AR 40-68 (TAB H of AIR)

2-6 Other military treatment facility organizational functions and committees

**b. Patient safety committee/function.** PD activities are designed to maintain and improve healthcare processes and practices, reduce the potential for harm to patients, and ensure the general safety and security of patient in all settings.

#### AR 40-3

11-11. Individuals authorized to write prescriptions

*a.* The following categories of personnel are authorized to write prescriptions:

(1) Uniformed and civilian physicians, dentists, veterinarians, and podiatrists engaged in professional practice at uniformed services MTFs.

*b.* The following personnel are authorized to write prescriptions only for selected medications as established under the provisions of AR 40-68:

(1) Uniformed and civilian optometrists, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners (NPs), physician assistants (PAs), physical therapists, occupational therapists, and clinical pharmacists engaged in professional practice at uniformed services MTFs and privileged to prescribe medications.

#### AR 40-3

11-12. Signatures

*a.* With the exception of physician order entry via the CHCS, no prescription or order will be filled in the pharmacy unless it bears the signature of an individual authorized to write prescriptions. Signature stamps are not authorized for prescriptions. The pharmacy service will maintain a system that allows their staff to validate the signature of individuals privileged to write prescriptions within their MTF.

#### ANALYSIS

X notified supervisors that duties were beyond her scope of practice as follows:

**TAB M, pg. 3 Answer 8 of AIR X notifies Dr. Gilbert and Major Ricardo after she was aware that she was to initiate the INH prescriptions and told them that was the scope of an Advanced Practice Register Nurse (APRN).**

**TAB M pg. 4 Answer 9 OF AIR Supervisor, Major Ricardo notified by X early in employment when she learned of having to prescribe medication When Dr. Gilbert showed X an outdated SOP that stated the CHN would prescribe initial dose of INH, X told him that was beyond her scope of practice and the SOP was outdated.**

**TAB A pg. 20 of AIR statement of Dr Gilbert that X asked if he would show her how to do the assessments and she could gain working experience.**

**TAB M of AIR On Oct 5, 2010 Major Ricardo gave X a counseling letter after meeting regarding X not being trained and being expected to perform duties untrained with Major Ricardo, Col Parsons, RPh, Pharmacy Chief, Barbara Davis Union Rep (X brought to meeting ) and B. Downing, CHN, DSN**

**Exhibit B-2 Oct 10, 2010, X letter to Major Ricardo regarding hostile environment and not being trained. Major Ricardo called B Downing, CHN, DSN and X into the office and told Downing that she was to orientate X by Oct. 13, 2010.**

**Exhibit B- 5 X sent email December 28, 2010 email to Col Renta, MD Medical Command Director, Col Campbell, APRN Nurse Commander, Major Ricardo, MSN Chief Preventive Medicine and Dr Gilbert, Retired Navy Captain, Occupational Health Physician, Preventive Medicine with specific and significant patient safety issues needing correction. X wrote she was practicing out of her nursing scope, was mistakenly in AHLTA as provider, there were**

no current SOPs guiding practice and X's name was on the medication as a provider. X requested corrections to these unsafe conditions.

**TAB M, pg. 4 Answer 9 of AIR** X told Major Ricardo that diagnosing and treating patients was beyond her scope Dec 23, 2010

**TAB M pg. 4 Answer 9 of AIR** When X discovered her name was on the INH bottles as prescriber, X notified the command staff via email. X talked with LT Col Parsons, Chief of Pharmacy to have a report run of all bottles with X's name on them as provider. X asked LT Col Parsons to remove her name as prescriber; if they were refills, they should have the original prescribing provider's name: Dr. Gilbert.

**TAB N of AIR Answer 12** Major Ricardo stated X went to Pharmacist Chief, LT COL Parsons and asked for X's name to be taken off all prescriptions and that I had sent an email to Major Ricardo's supervisor but she neglected to say her name was also on the email. **Exhibit B-5**

**TAB A pg. 24 of AIR LT COL Parsons** stated that he told X; he would run the reports, but he never gave them to X or anyone and destroyed them. He also stated that X was licensed and credentialed to renew prescriptions for INH. "Therefore Ms. X was allowed to put into CHCS **new prescriptions for INH using her name as the provider**".

**TAB A pg. 24 of AIR COL Campbell** was quoted as saying "Ms X informed MAJ Ricardo of her concerns regarding performance of duties within the first couple of months of employment". COL Campbell stated she was on the safety committee and nothing was brought to her. **Her answer to the email Exhibit B-6** state that there were no problems with X renewing medication with an SOP. She totally missed that the INH was not a refill but was a new prescription every time I ordered INH for a patient which was Illegal.

**Exhibit B-1** October 5 counseling letter from meeting where X stated she was not being trained.

**Exhibit B-2** Letter to Major Ricardo stating X not being trained and in working in hostile environment

**Exhibit B-3** Email from X to Major Ricardo asking to go to union representative

**Exhibit B4** The copy of the prescription bottle is **not a refill** and the pharmacist filled it with **X name as provider**. X is not a provider The medication was marked with 0 of 0 refills; no matter if it was the first or last bottle of INH, as the patients were required to visit the CHN each month for a new prescription. X's name was in the electronic health record as a Provider (APRN CHN privileges) and that is why her name was on the medication . X was prescribing the medication each month not a filling a refill of INH.

**Exhibit B-5** Email to command medical staff regarding specific and substantial safety issues of patient care

**Exhibit B-6** Response from COL W. Campbell, APRN

**Exhibit B-7** Response from X to COL Campbell

**Exhibit B-8** Sample procedure for electronic refills of prescriptions by nurses and signed by physician. This is from a non governmental medical group and is standard of practice for electronic generated prescriptions pended ny registered nurses who are not Nurse Practitioners.

**Exhibit B-9 Copy of FEDERAL HITECH ACT 2009** Meaningful use-how a nurse can pend orders in electronic health record, but physician must co-sign.

**Exhibit B- 10 Coast Guard Manual on M6000.1E Signatures on prescriptions need provider professional discipline.** This should also be true of any TRICARE military, including Army. Yet only X last name and a number were on the prescription bottles. (what DOES number mean?)

**Exhibit B-11** Report on **Provider File Errors** for 7 Army Clinics including **Lyster Army Health Clinic**

**Exhibit B-12, B 13** Evaluation of Clinical Privilege's Department of Army form **5441-47** as required for evaluation of CHN, AR 40-48 2-3 c (2)

**TAB A of AIR pg 23 paragraph 2 Major Ricardo states that if X had advised her of concern on name of bottle, she would have resolved it. Yet she was notified Exhibit B-5 on December 28 email along with command staff that her name was on the bottle of INH and did nothing to correct this except to tell X she bordered on insubordination( counseling letter dated January 4, 2011) by going to the pharmacist and telling her afterwards on January 3, 2011.**

**Major Ricardo, Dr. Gilbert, COL W. Campbell, APRN, Chief Nurse and Chief Physician, D. Renta of Lyster Army Health Center and Chief of Pharmacy, Col Parsons were all notified of the error of X in AHLTA as a provider and that the medication was not a refill of original prescription by Dr. Gilbert, but it was being processed as a prescription with X as original provider. In Exhibits B are samples of what the community standards for electronic records are for a Advance Practice Registered Nurse (APRN) not needing a co-signer. This means that a non APRN CHN nurse needed a co-signer and a sample of the community standard of the provider's professional status to be on bottles of medication.**

**X also notified the Command staff that the SOPS were not updated and some were simply non-existent. None of the above command staff attempted to rectify the incorrect provider status in AHLTA or ensure the SOPs for all of the patient centered Preventive Medicine duties were up to date and were available. The Nurse Commander sent a return email stating that was the practice at Lyster Army Health Center. The Preventive Medicine Chief gave X a counseling letter stating if she did not abide by policy, she would face adverse action. X was not trained, was ordered to practice outside her nursing scope of practice and notified supervisors on several occasions.**

**Lyster Army Health Center violated Army Regulations regarding granting privileges without appropriate credentials, not training and evaluating X for competency before allowing her to order medication with her patients, not having a physician supervisor noted in written plan, and disregarding patient safety issues.**

## **CONCLUSION**

**Lyster Army Health Center Command staff had a fiduciary obligation when notified of unsafe clinical care and practices to correct them. The Lyster Army Health Center Medical Command staff abused their authority and did not attempt to correct a substantial and specific danger to public health or safety. Lyster Army Health Center Medical Command staff violated several Army regulations by failing to correct unsafe clinical care and practices.**

## **ISSUE IV DID LACH PREVENTIVE MEDICINE HAVE VALID SOP/CPGS FOR STD/STI,TB**

### **AR 40-48**

**Nurse Practitioners, Certified Nurse Midwives, Community Health Nurses, and Certified Registered Nurse Anesthetists**

#### **2-1. Privileges**

**Prior to applying for clinical privileges, each nurse practitioner (NP), certified nurse midwife (CNM), community health nurse (CHN), and certified registered nurse anesthetist (CRNA) will meet the criteria for his/her clinical**

specialty as listed by definition in Section II, Terms. The policies and procedures for credentials review and clinical privileging will be consistent with AR 40-68. The individual's completed application and practitioner credentials file(PCF) will be submitted to the chief nurse (CN) for review, concurrence, and signature prior to being forwarded to the credentials committee. The credentials committee will recommend and the MTF commander will approve clinical privileges that are based on pre-established practice protocols/clinical practice guidelines (CPGs) discussed in *a* through *c* below. (See AR 40-68 for detailed privileging guidance and information on credentials committees.)

*c. Community health nurse.* The CHN and the designated physician supervisor will establish mutually agreed upon practice protocols/CPGs. These practice protocols/CPGs will be signed by the supervising physician, the individual CHN, the chiefs of community health nursing and preventive medicine, and the CN. Drugs approved for prescription writing will be included as part of the recommended clinical privileges. Practice protocols/CPGs will be reviewed annually and updated as necessary.

## ANALYSIS

TAB N-12 of AIR is a regulation for Sexually Transmitted Diseases –**NOT an SOP** and is signed by **non-medical** Commander and his Chief, Administrative Services. This is the regulation that Major Ricardo presented to X on December 23, 2010 when Major Ricardo wrote( in pen on page 5 of the regulation). **AR 40-48 2-1c is specific that the supervising physician , chief of Preventive Medicine and the CHN should sign and update the SOP/CPG.** This is also the standard of care for non military medical services.

Tab N-13 of AIR is the SOP for the Tuberculosis program and is vague as to who furnishes the initial dose of INH. On page 5 of this SOP is states ' Performance Improvement program a. the preventive medicine (PM) physician will review all TB chemoprophylaxis initiation for appropriate therapy'-**does that mean the CHN prescribes it and the physician reviews???? This 2008 SOP (CPG) was signed on ????** by Andrew Barber J.R. , MD Occupational Health Physician and Gwendolyn L. Davis Chief Preventive Medicine.-neither of whom were at the facility; therefore was not a valid SOP (CPG).

TAB A of AIR pg. 35 Col Bayles is quoted as stating' "Our role is not diagnose and treatment, but ensuring that the public health concerns with the aforementioned condition have been adequately addressed. That includes contact tracing and reporting. It also includes ensuring that the individual received the proper treatment in accordance with the CDC guidelines.

The Regulation for STD was a regulation not an SOP/CPG and was signed by non medical personnel; therefore was not valid as an SOP. The 2008 SOP for TB was vague as to duties and the people who signed it were no longer there. Army regulation 40-48 2-1 c. The CHN and the designated physician supervisor will establish mutually agreed upon practice protocols/CPGs. These practice protocols/CPGs will be signed by the supervising physician, the individual CHN, the chiefs of community health nursing and preventive medicine, and the CN. Drugs approved for prescription writing will be included as part of the recommended clinical privileges. Practice protocols/CPGs will be reviewed annually and updated as necessary. Lyster Army Health Clinic Preventive Medicine did not have valid SOP/CPGs as required by Army regulations.

## CONCLUSION

LAHC Preventive Medicine Department not only did not have valid SOP/CPGs for STD/STI, they also did not have valid SOP/CPG for HIV or Epidemiological Investigations. Army regulations were violated by not

having valid SOP/CPG and LAHC Medical Command Staff is negligent; as they were notified of the fact (Issue III) and took no actions to correct the unsafe health and safety issue.

## ISSUE V. EXISTENCE OF SUBSTANTIAL AND SPECIFIC DANGER TO PUBLIC HEALTH AND SAFETY

### AR 40-68

#### 1-4. Responsibilities

*i* (2) **Deputy commander for nursing (DCN) (or comparable title).** The DCN is/will—

- (a) A licensed professional registered nurse.
- (b) The principal executive staff advisor to the commander on matters concerning the scope of patient care services and clinical policy (specifically related to the provision of nursing care and services and nurse staffing standards), nursing policy, and the availability and utilization of nursing resources.
- (c) Act as liaison between members of the nursing staff and the commander and, as such, advocate for the provision of quality nursing care, treatment, and services.
- (d) Participate in the development, implementation, and integration into the organization's overall plan for patient care, policies and procedures that guide and support the provision of quality patient care services.
- (e) A voting member of the ECMS (or comparably named committee).
- (f) Ensure PI activities are in place in all and actively participate in these processes. arenas in which nursing care, treatment, or services are rendered
- (g) A voting member of the MTF credentials committee with responsibility for review and concurrence with scope of practice and privileges for nursing personnel.
- (h) Reduce or appropriately limit the scope of practice of any nursing staff member whose competence, quality of care, behavior/conduct threatens the health or safety of any patient, employee, or other individual until the matter is investigated and resolved according to the provisions outlined in this regulation. (See chap 9.)
- (i) Support and actively engage in an ongoing, proactive program for identifying PS risks and for reducing nursing/healthcare errors according to DOD 6025.13-R and USAMEDCOM guidance.

### AR 40-68

#### 10-2. Command responsibility

*a.* Action taken on the part of the commander against a provider's privileges (professional's scope of practice) may be warranted based on performance suspected or deemed not to be in the best interest of quality patient care. These actions include holding in abeyance, denying, suspending, restricting, reducing, or revoking clinical privileges/practice.

The action taken may be immediate (summary) in the event of a critical incident or as a result of the credential committee's deliberation (routine) on information made available through CQM reporting channels.

*b.* The commander's prerogative to hold in abeyance, to deny, or to summarily suspend clinical privileges/practice is exercised when there is reasonable cause to doubt the individual's competence to practice or for any other cause affecting the safety of patients or others. Reasonable cause includes—

- (2) A pattern of inappropriate prescribing.

**AR 40-3****11-2. Responsibilities**

*a.* The MTF commander, who also routinely serves as the Army installation (in garrison) Director of Health Services, will operate the pharmacy and all aspects of medication management and appropriate and safe drug therapy and will exercise careful supervision over all phases of pharmacy operations and medication management throughout the command. This includes employment of recognized professional procedures and establishment and aggressive pursuit of those policies that ensure conformity with the highest standards of the pharmaceutical profession. **The commander will ensure that—**

**(1) Supervision is exercised directly by—**

*(a)* A **pharmacy officer** or civilian pharmacist who is a graduate of a recognized school or college of pharmacy and licensed to practice pharmacy in one of the States of the United States, Puerto Rico, or the District of Columbia.

**(2) Policies will be established to ensure—**

*(e)* **Adherence to appropriate credentialing and privileging procedures, guidelines, and mandates according to Federal law, ARs, DODDs and/or Department of Defense Instructions (DODIs), an accrediting body (for example, TJC**

**or other), and other regulatory agency requirements for dispensing medication.**

*b.* **The Chief, Pharmacy Services (note: exact title of the chief of pharmacy varies depending on local designation) will be charged with the duties of recognizing, identifying, selecting, ordering, preparing, safeguarding, evaluating, and dispensing all pharmaceutical substances (of whatever kind and combination) used in preventive, curative, and diagnostic medicine. The chief and his/her staff will be responsible for keeping abreast of new developments in the field of pharmacy and for operating the pharmacy in compliance with Federal laws, accreditation standards defined by the current accrediting body (for example, TJC or other), and standards of pharmaceutical care within the community.**

In doing so, the chief will—

**(1) Assist and advise health care providers in the writing of prescriptions, medication orders, and other matters involving the use or misuse of medications.**

**AR 40-3****11-7. Pharmacy and therapeutics committee**

*a. Establishment.* The MTF commander will appoint the P&T committee.

*b. Composition.* The committee will include a mixture of clinical and administrative staff so that all specialties are represented to the maximum extent possible.

*c. Objective.* The primary objectives of the P&T committee are—

**(1) Advisory. The committee recommends the adoption of and assists in the formulation of broad professional policies regarding the Medication Management System to include evaluation, selection, procurement, distribution, use, safe practices, and other matters related to therapeutic agents.**

**AR 40-3****11-9 Performance improvement**

*a. Performance improvement process.* **The Chief, Pharmacy Services will implement an internal process that will demonstrate improvement in pharmacy services. This process will be integrated with the MTF's organizational performance improvement structure and documentation will provide evidence of ongoing improvement according to AR 40-68.**

*b. Recording and reporting medication errors.* The recording and analysis of all MTF adverse events/medication errors will be according to AR 40-68 and current USAMEDCOM guidance and will utilize the standardized/automated DOD medication error reporting system (for example, MedMARx or other).

**(1) The implementation of medication error documentation (for example, MedMARx) will be accomplished through a multi-disciplinary approach. The patient safety manager and the chief pharmacist will work together to assume leadership and coordination of the local program.**

(4) A root cause analysis, in accordance with the Patient Safety Program, USAMEDCOM, and current accrediting body's (for example, TJC or other) standards, will be conducted on any error in categories G through I and as deemed appropriate by the specific MTF.

(5) Copies of the form may be provided to individuals, services, or departments deemed appropriate to clarify and rectify the problem according to AR 40-68.

#### AR 40-3

11-11. Individuals authorized to write prescriptions

a. The following categories of personnel are authorized to write prescriptions:

(1) Uniformed and civilian physicians, dentists, veterinarians, and podiatrists engaged in professional practice at uniformed services MTFs.

b. The following personnel are authorized to write prescriptions only for selected medications as established under the provisions of AR 40-68:

(1) Uniformed and civilian optometrists, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners (NPs), physician assistants (PAs), physical therapists, occupational therapists, and clinical pharmacists engaged in professional practice at uniformed services MTFs and privileged to prescribe medications.

#### AR 40-3

11-12. Signatures

a. With the exception of physician order entry via the CHCS, no prescription or order will be filled in the pharmacy unless it bears the signature of an individual authorized to write prescriptions. Signature stamps are not authorized for prescriptions. The pharmacy service will maintain a system that allows their staff to validate the signature of individuals privileged to write prescriptions within their MTF.

#### DOD 6025.13-R

**DL1.1.16.** Healthcare Practitioner. Synonymous with "healthcare professional."

Any physician, dentist, or healthcare practitioner of one of the professions whose members are required to possess a professional license or other similar authorization. These include DoD healthcare personnel who are physicians, dentists, registered nurses, practical nurses, physical therapists, podiatrists, optometrists, clinical dietitians, social workers, clinical pharmacists, clinical psychologists, occupational therapists, audiologists, speech pathologists, physician assistants, or any other person providing direct patient care as may be designated by the ASD(HA).

**DL1.1.17.** Healthcare Provider. Military (Active or Reserve component) and civilian personnel (Civil Service and providers working under contractual or similar arrangement) granted privileges to diagnose, initiate, alter, or terminate healthcare treatment regimens within the scope of his or her license, certification, or registration. This category includes physicians, dentists, nurse practitioners, nurse anesthetists, nurse midwives, physical therapists, podiatrists, optometrists, clinical dietitians, social workers, clinical pharmacists, clinical psychologists, occupational therapists, audiologists, speech pathologists, physician assistants, or any other person providing direct patient care as may be designated by the ASD(HA). This term is equivalent to Licensed Independent Practitioner (LIP). (See DL1.1.24.)

**DL1.1.24.** Licensed Independent Practitioner. Any individual permitted by law and by the organization to provide care, treatment and services, without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical privileges. This term is equivalent to Healthcare Provider. (See

DL1.1.17.)

**AR 40-48**

Nurse Practitioners, Certified Nurse Midwives, Community Health Nurses, and Certified Registered Nurse Anesthetists

**2-1. Privileges**

Prior to applying for clinical privileges, each nurse practitioner (NP), certified nurse midwife (CNM), **community health nurse (CHN)**, and certified registered nurse anesthetist (CRNA) will **meet the criteria for his/her clinical specialty as listed by definition in Section II, Terms**. The policies and procedures for credentials review and clinical privileging will be consistent with AR 40-68. The individual's completed application and practitioner credentials file

**AR 40-48**

**Page 20** Terms and Conditions

Community health nurse

**A registered nurse who has successfully completed a post baccalaureate program of study (for example, Principles of Military Preventive Medicine 6A-F5) which prepares the registered nurse to provide family-centered nursing services to individuals, families, and groups in the community which include epidemiological and health promotion support.**

**ANALYSIS**

**TAB N pg. 4 of AIR** Major Ricardo testified on question 16 –answer 16' No patients were injured as a result of Ms X's actions. There is evidence that Ms X neglected to document on follow up cases'. However , **TAB N-9 of AIR** email evidence that X gave Major Ricardo a verbal report on those two patients who had appointments needing refills and would return to clinic the next day. Since X was not there, it was Major Ricardo's responsibility to provide CHN coverage, which she did.

**TAB N-1 of AIR pg 2** X email to Major Ricardo reiterating X gave her report on two patients who needed refills and two patients who had appointments the next day. These were the patients Major Ricardo said X did not document.

As noted in the laws, regulations analysis and conclusion of this report's Issue I, Issue II, Issue III and Issue IV; evidence is provided that X was not qualified to perform the functions of a CHN, was not trained, was not supervised and was not working with valid SOP/CGPs. When X reported the unsafe , specific and substantial dangers of patient care , she was ignored by the Army Command staff.

**Exhibit B-4** medicine refill bottle

**TAB A pg. 24 of AIR** LT COL Parsons stated that he told X; he would run the reports, but he never gave them to X or anyone and destroyed them. He also stated that **X was licensed and credentialed to renew prescriptions for INH. "Therefore Ms. X was allowed to put into CHCS new prescriptions for INH using her name as the provider"**.

**TAB A of AIR** , pg 28.states Although their are training programs provided by the U.S. Army MEDCOM for Army Nurse officers, on the job (OJT) is the primary means of training public health nurses such as Ms X.

**TAB A, pg. 40** Dr Gilbert is quoted as “After he expressed his concerns with Major Ricardo, Ms X consulted with him periodically on patients having their 30 day followups, and **to the best of Dr. Gilbert’s knowledge, she followed protocols.**

**TAB A of AIR pg. 25** states in the duties of a CHN at LAHC that investigation of communicable diseases, HIV, STD, Tuberculosis Control program, counseling for life style health risk, child and youth services consultant, special needs resource team and conduction of monthly inspections of CYS. The brief orientation **TAB N-5 and N-6 of AIR** was not formal training; it was an orientation to administrative processes.

**TAB A pg. 35** Col Bayles is quoted as stating’ **“Our role is not diagnose and treatment, but ensuring that the public health concerns with the aforementioned condition have been adequately addressed. That includes contact tracing and reporting. It also includes ensuring that the individual received the proper treatment in accordance with the CDC guidelines.**

**TAB A pg. 21 paragraph 1** states Dr. Gilbert testified that no patient was injured...Further , none of the patients MS. X cared for **with latent tuberculosis developed active tuberculosis which could have been a threat to public safety.....**

The ‘alleged refills’ of INH were **filled as an original prescription**, not as refills of a prescription with a licensed provider’s name such as Dr. Gilbert. The bottle labels contained the name X, number 6639 in the provider space and did not identify her professional status of RN on the bottle. **Was X on the list in the pharmacy as a privileged provider having been vetted by the ECMS credentialing committee and P&T committee to be able to have prescription writing privileges? Where is this evidence in the Army report?** According to Army Regulations a **registered nurse CHN needs a physician cosigner( after pending order in electronic record) and it is to be cosigned by supervising Provider (physician).**

**Who on the Lyster Army Health Clinic staff told the AHLTA system administrator to build X Provider privileges? X could order any medication or test, had she not been a conscientious nurse. X could have easily unknowingly overlooked a possible contraindication or a symptom which would cause damage to a patient’s health while on the INH, as her training was not adequate and she was not qualified for the position. Simply reading material from the CDC website does not make X, who did not have a Public Health Certificate, an expert and X was never tested for competency: in fact Dr Gilbert raised concerns to Major Ricardo about competency and Major Ricardo ignored them.**

When X raised concerns of **unsafe practices to the Medical Command staff and X’s supervisor and the Preventive Medicine Occupation Health physician, pharmacy chief----no corrective actions were taken;** other than a counseling letter to inform X that adverse conditions would occur to me if X did not follow orders. **Why did the Pharmacist not give X the list of prescriptions with her name as prescriber as she requested? LT COL Parson further stated he gave it to no one and threw it away in three days. What was he hiding? If the records were furnished it would show that X’s name was the prescriber on the prescription of many bottles and none were refills- they all have 0 of 0 refills as X was erroneously in the electronic health system as a privileged provider. When X ordered labs, the results returned to X who could have ordered medication of any type or more tests of any type because X was a provider in AHLTA. TAB A of AIR pg 40 states “to the best of is knowledge” demonstrating X was not being supervised. TAB A of AIR, pg 35 Col Bayles states our role is not diagnose and treatment. Yet the STI regulation signed by non medical command staff and assistant lacking a current physician signature was submitted as an SOP.**

X was listed as a provider in the Army CHCS and AHLTA electronic health record systems which enabled her to prescribe medication and tests. According to DOD 6025.13-R, X did not meet the requirements of a provider. X could have ordered any medication or lab test on anyone X picked in the electronic health record. This is a very substantial and specific danger to public safety of the armed forces patients; as X had never been clinically trained and was not licensed to perform these tasks.

LT COL Parsons admits in the report that X " was allowed to put into CHCS new prescriptions using her name as prescribing provider. The Command staff ,who had a fiduciary duty to correct unsafe practices; chose to ignore X's report of unsafe specific and substantial practices. X was aware of the danger of being unqualified and untrained with no supervision or competency training, no valid SOP/CPGs , the fact no one would change the status from provider in the electronic health record ; she was accountable for her actions and notified her command, who did not take action to correct safety issues. X she became ill thinking of the dangers to her patients and notified the Army Inspector General who suggested submitting her concerns to the Office of Special Investigations. The Lyster Army Health Center , Army Medical Command had a fiduciary duty to protect the safety of their patients ; they chose to ignore the pleas of X that she was not qualified, not trained, not physician supervised, there were no valid up to date SOP for STD, TB and HIV and no existing SOPs for investigating epidemiological communicable diseases such as food poisoning and X was given provider privileges in the Army electronic record.

Because X was not qualified, trained, she was not supervised by a physician, there were no valid SOP/CPGs, she was able to have provider privileges in the computer electronic record and her job entailed caring for patients with communicable diseases such as epidemiological-food poisoning, sexually transmitted diseases including HIV and tuberculosis ,she was a threat to the patients she cared for as a CHN. Dr. Gilbert is quoted as testifying that none of the patients X cared for developed active tuberculosis which could have been a threat to safety. Another danger to public health and safety was the fact X had provider privileges in the electronic health record and could order any drug for anyone; the recipient of the drug prescribed by X could be in danger. HIV can be a fatal disease ,is highly communicable and has it's own Army regulation AR 600-110 which contains very extensive information on safeguards prevent HIV positive soldiers from transmitting HIV to others. Several sexually transmitted diseases such as HIV, hepatitis A, B,C and herpes are lifetime afflictions and if not treated properly can lead to serious health problems. Because these are lifetime afflictions the conditions must be properly monitored, re-assessed by a healthcare provider and the patient must be properly educated on transmission of their disease. Other sexually transmitted diseases can lead to serious health problems if not treated properly. Some STI symptoms may actually not be an STI, but a medical problem and that is why patients should be examined, diagnosed and treated by a healthcare provider.

Tuberculosis (TB active or latent is a diagnosis to made by a healthcare provider and is to be initially treated with medication from a provider with lab test at intervals. X was expected to assess and initiate the treatment and was actually prescribing the INH treatment and was not qualified as a healthcare provider; a person with latent TB could actually progress to active TB and infect several people, which poses a public health danger. There were no SOP/CPGs for investigation of epidemiological diseases, only an orientation of the paperwork to file an investigation report to the Public Health Department and in the Military communicable disease system and to ask the questions on the Public Health form. An out break of several patients having food poisoning would have been impeded and a serious threat to public health safety would have occurred. Homeland Security and CDC surveillance of massive numbers of food poisoning outbreaks for possible acts of terrorism.

Fort Rucker, Lyster Army Health Clinic service the health needs of Flight personnel and Pilots of aircraft. Because X was not qualified, given a structured training and supervision from a physician, there were no specific SOPs/CPGs relating to care of Flight personnel and pilots in taking medications and the SOPs were

not current or signed by a physician; there existed a margin of error in their treatment of TB and STIs by X, which could have lead to a danger of the flight personnel and pilots being cleared for flight duty.

## CONCLUSION

A substantial and specific danger to public health and safety existed by X not being a qualified individual, not having structured physician supervised training, LAHC not having current physician signed SOPs/CPGs and Medical Command Staff not taking any actions to rectify serious specific unsafe practices when notified by X. The LAHC Medical Command staff is negligent and violated several Army regulations.

## ISSUE VI. ARMY INVESTIGATIVE REPORT INTENTIONAL OMISSIONS AND INCONSISTENCIES TO ENCOURAGE OSC RULING IN ARMY FAVOR

### AR 15-6

#### 3-8. Witnesses

##### *c. Taking testimony or statements.*

(2) In informal proceedings, statements of witnesses may be obtained at informal sessions in which they first relate their knowledge and then summarize those statements in writing. A tape recorder may be used to facilitate later preparation of written statements, but the witness will be informed if one is used. The investigating officer or board will assist the witness in preparing a written statement to avoid inclusion of irrelevant material or the omission of important facts and circumstances. However, care must be taken to ensure that the statement is phrased in the words of the witness. The interviewer must scrupulously avoid coaching the witness or suggesting the existence or nonexistence of material facts. **The witness may be asked to read, correct, and sign the final statement.**

(3) Whether the witness swears to the statement is within the discretion of the investigating officer or president. If the statement is to be sworn, use of DA Form 2823 (Sworn Statement) is recommended. **If the witness is unavailable or refuses to sign, the person who took the statement will note, over his or her own signature, the reasons the witness has not signed and will certify that the statement is an accurate summary of what the witness said.**

## ANALYSIS

**TAB D of AIR** in Memo to Col Justin A. Woodhouse on subject of appointment as investigating officer. Pursuant to AR 15-6. from Ted Wong, Major General, DC Commanding; 5. You should contact witnesses you consider relevant during the course of your investigation. **You are to thoroughly document all witness interviews in writing, preferably on DA Form 2823 (Sworn Statement), and have witnesses certify their statements when final.** 6. All witness statements will be written (typed or block printed) and sworn. You will interview all witnesses in person, if practical. 10. You will submit your completed investigation on a DA Form 1574 with a table of contents and enclosures. **The enclosures will include all documentary materials considered by you..**

**TAB A of AIR pg. 35,** Interviewed Col Bayles who provided the following information regarding tasks which would properly be within the scope of duties for a CHN: "... Text..." This is information that is noted by ... what is missing there? Since evidence is not provided of a certified or sworn testimony; who knows what is missing.. "

**TAB A of AIR pg 3 paragraph 3** reads In his testimony, COL Bayles.... Where is the evidence of his testimony?

**TAB A of AIR pg. 37 paragraph 2, sentence 6** “and she (referring to MJ Ricardo) that based on her research and consultation with the California BRN, the CPGs developed by LACH are consistent with the State’s scope of practice” Nowhere is this noted in her sworn testimony-in addition to this not being in her testimony; **TAB N-14 of AIR pg. 2** clearly states in email from CA BRN that they were unable to review attached documents” which are referenced as SOP documents in **TAB N-14 of AIR pg 3.**

**TAB A of AIR pg. 37** COL Campbell quoted as saying there were no adverse affects over X reluctance to perform duties and X had not been disciplined.

The Army Report of Investigation **did not include all witness signed statements or sworn testimony. X and Major Ricardo were the only sworn testimonies** included TAB M & N of AIR. Paul Macias testimony was signed and included in TAB Q of AIR. According to the above AR 15-6 and the Major General’s instruction all people interviewed were to be included in report. As the report is written it is not clear that the witness quotations were fact or if they were fiction. **Several witnesses were quoted and there is no evidence of their testimony.**

**The report omitted AR 40-48 and AR 40-03** which contained specific information on the qualifications of a CHN and on pharmacy protocol . **Omission of these two regulations and the omission of the testimony sworn /certified by interviewees who were quoted is simply negligent investigation or intentional.**

**The Army report was to include any adverse actions regarding informing her supervisors of unsafe practices- this was not written in the report.** X was given a counseling letter telling her if she did not follow orders she would face adverse consequences including being discharged from Federal service which caused X a great deal of stress. X sought medical attention and was not medically cleared to return to work. After taking FMLA leave, the doctor wrote a letter to Major Ricardo stating X should be able to return to work on November 11, 2011. Major Ricardo sent letters to X stating that if she did not return to work on October 7, 2011 , she would be charged AWOL and could be terminated.-that letter was not included. **X never held a nursing job that allowed a nurse to return to a patient care position without having a medical clearance from her health care provider. Medical regulation 4-501 states that soldiers are to have a medical clearance to return to duty. OWCP FECA does not allow injured workers to return to work unless medically cleared. In view of the above, X should have been medically cleared to return to work-she was not and was terminated because she was not medically cleared to return to work and marked AWOL when her supervisor had been given a letter stating such.**

Major Ricardo telephoned X in September and asked if X intended to return to work . X assured her that she did. X also sent Major Ricardo a letter stating that X was not medically able to return to work on October 7, 2011 and that X intended to return to work when she was healthy. This also was not included in this report. The Army investigator was allowed to have several extensions to complete the report and still did not include that X was terminated for AWOL while ill and not medically clear to return to work (Major Ricardo was in possession of letters from doctors and emails from X regarding that she was unable to return to work).

**Evidence has intentionally been left out to sway opinion that X was qualified. The report left out the sworn or certified testimony of the witnesses so that all questions asked and answered were not included, only what the investigator chose to include making it difficult to establish existence of subjective and objective fact or fiction testimony. X was terminated for AWOL when in fact she was not medically cleared to return to work.**

#### Conclusion:

**The Army Investigative Report contains intentional omissions , inconsistencies and a statement that Major Ricardo testified that SOPs were consistent with CA BRN ( this was not in her sworn testimony and email evidence does not indicate this) to encourage an Office of Special Counsel ruling in the favor of the Army.**