

NOV 21 2013

Indian Health Service
Rockville MD 20852

Ms. Carolyn Lerner
The Special Counsel
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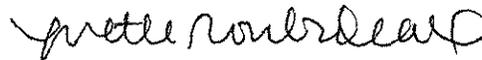
Dear Ms. Lerner:

I am responding to an October 21, 2013, e-mail from Ms. Karen Gorman, Deputy Chief, Disclosure Unit, U.S. Office of Special Counsel (OSC), to Mr. Oliver Potts, Deputy Executive Secretary, Department of Health and Human Services (HHS), which details OSC concerns with the initial report of findings submitted in July 2013 for OSC File No. DI-12-3553. The report concerns a Whistleblower disclosure that the OSC received from a former employee of the Indian Health Service, Browning Service Unit, Blackfeet Community Hospital, in Browning, Montana.

The Secretary of HHS has delegated me the authority to sign this report and to take actions necessary under 5 U.S.C. § 1213(d)(5). In the coming weeks, I will issue a memo to Agency staff on Privacy Act guidelines.

I respectfully submit the enclosed revised report of findings for OSC File Number DI-12-3553. Please contact me at (301) 443-1083 if you have questions.

Sincerely,



Yvette Roubideaux, M.D., M.P.H.
Acting Director

Enclosure

U.S. OFFICE OF
SPECIAL COUNSEL
WASHINGTON, D.C.
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U.S. Office of Special Counsel (OSC)

OSC File No. DI-12-3553

U.S. Department of Health and Human Services

Indian Health Service (IHS)

Submitted by: Yvette Roubideaux, M.D., M.P.H., Acting Director, IHS

Yvette Roubideaux

Report of Findings

1) Summary of the information on the investigation:

On March 21, 2013, the Indian Health Service (IHS) initiated an investigation regarding Office of Special Counsel (OSC) File No. DI-12-3553. The investigation was completed by the following employees at the Indian Health Service, Billings Area Office, Billings, Montana.

- Ms. Kayte Pratt, Registered Nurse (RN), Area Nurse Consultant, Office of Healthcare Programs (OHCP).
- CAPT James Sabatinos, Advanced Practice Registered Nurse (APRN), Area Compliance Officer, OHCP.

The investigation was conducted in response to the letter from the OSC, dated January 23, 2013, regarding OSC File No. DI-12-3553 outlining allegations in the context of whistleblower disclosure.

2) Description of the conduct of the investigation:

- A. On March 26, 2013, a meeting was conducted between CAPT Sabatinos, Ms. Pratt and Ms. Kim Nicholson, Human Resource Specialist, Northern Plains Human Resources (NPHR), to obtain guidance for conducting administrative investigations (The Best of Soelr 2003, Administrative Investigations Handout) (Attachment 1).
- B. On March 27 - 28, 2013, CAPT Sabatinos and Ms. Pratt conducted an onsite investigation at the Blackfeet Community Hospital (BCH), Browning, Montana, regarding employee misconduct with respect to patient care and facility security.
- C. During the onsite investigation on March 27- 28, 2013 Ms. Pratt and CAPT Sabatinos conducted face to face interviews with the following staff:
 - Mr. Merlin Gilham, Chief Executive Officer (CEO)
 - Ms. Susan Head, RN, Director of Nurses (DON)
 - Ms. Linda Dusterhoff, APRN, Quality Assurance Officer (QAO)
 - Maintenance/Facilities workers general and Biomed
 - Ms. Eva Racine, RN (Outpatient Nursing Supervisor)
 - Inpatient unit day shift nursing staff
 - Mr. Sheldon Williamson, Security Guard
 - Ms. Mary Connelly, RN (inpatient unit night shift staff)
 - Night shift inpatient nursing staff
 - Emergency Room (ER) night shift nursing staff
 - Dr. Ernest Grey, MD, Chief Medical Officer (CMO)
 - Ms. Wanda Lahr, lead timekeeper

- D. CAPT Sabatinos conducted an onsite visit to BCH during the night shift March 28, 2013, at 3 a.m. He interviewed staff on duty inside the hospital and conducted an assessment of the exterior lighting and overall safety.
- E. A telephone interview was conducted on March 27, 2013, at 8:30 a.m. with Ms. Dawson, RN. Ms. Dawson verified that she was hired at BCH in July 2011. She stated her previous professional nursing experience included a Federally Qualified Health Center in Las Cruces, New Mexico for primarily migrant and low income clients in an outpatient clinic setting. Ms. Dawson stated that she is not American Indian/Alaska Native. She also stated that she loved taking care of Native American patients and respected them, which was the primary reason for applying for a job with the Indian Health Service (IHS). She holds a valid nursing license in Montana and when employed at the BCH also had an Oregon nursing license. Ms. Dawson had previous hospital experience at Whiteriver PHS Indian Hospital, White River, Arizona. She stated that the experience did not go well and she was terminated after two weeks as a result of work; she was yelled at by a co-worker and counseled by management. Ms. Dawson complained to management about patient care concerns which in her opinion led to her termination at Whiteriver. She further stated that she hated going to work at Whiteriver. Ms. Dawson relates that she has high standards for patient care as a nurse and states this may put her in conflict with other staff who do not share the same high standards for providing high quality nursing care.

Initially, Ms. Dawson was excited about being hired at BCH and was looking forward to working with obstetrical patients. She described her orientation as “figure it out on my own” however; she praised her clinical preceptor, Ms. Racine, as one who addressed clinical competency for inpatient clinical nursing at BCH with her. She admitted numerous problems while at BCH.

In regards to complaints about government quarters, Ms. Dawson said she believed it was not safe to live there. She and her husband encountered a peeping Tom on two occasions; in one instance the person ran away before help could arrive. On another occasion she states her husband held the prowler at gun point until Blackfeet Tribal police responded to their call for help. She also stated that there were packs of stray dogs that roam freely around the government housing area and all over the hospital grounds. She reports that she became afraid to walk even a short distance from her home in the government housing area to the hospital due to poor lighting and fears about wandering dogs and reports of rampant vandalism, theft, and property destruction that she either experienced, witnessed or was told about by other co-workers.

The complainant is allergic to cigarette smoke and was often exposed to second hand cigarette smoke as the smoke came into the hospital from the door entrances, as a result of staff and visitors standing near hospital entrances to smoke. Ms. Dawson reports that several times she experienced breathing difficulties while at work.

In regards to patient care by nursing staff on the inpatient unit, Ms. Dawson stated she is primarily a night nurse and had worked a few day shifts. Most of her work at BCH was

on the night shift inpatient unit. She stated that nursing staff including RN's and Certified Nursing Assistants (CNA) would disappear for long periods of time without explanation. She alleged that often the patients were over medicated with Ativan and would sleep through the night allowing nurses to leave the unit for long breaks or to sleep on the job. Medications are delivered via Pyxis controlled access system.

Ms. Dawson stated that the patient loads were heavy and often felt the number and types of patients assigned for her to care for during a shift were "overwhelming." She stated the patient loads were assigned unfairly and she frequently had unfairly been assigned more work than other nurses. The acuity level of the patients she cared for while at BCH was intense. She reported that one shift was particularly difficult in that she cared for two sick newborns, a sick postpartum patient, and had a code that night as well. There had been a patient death earlier in the day. Ms. Dawson stated she "lost it" after a "code" on another patient that night, and while on duty locked herself in the medication room so she could cry alone for a period of time after the code was completed.

Ms. Dawson stated she later found out that some nurses had complained about her skill competency level with codes. She also was "written-up" for improperly administering medication to a small child, and stated she directed the mother to administer the medication instead of the nurse. She admitted she forgot two doses of albuterol for a patient and, in her opinion, this had "not been a big deal." I asked Ms. Dawson who she reported these concerns to and she stated Ms. Head, DON. I asked her who her immediate supervisor was and she said it was Ms. Head. Ms. Dawson admitted it was possible there were other nurses and could not remember the names of the individuals who were acting as supervisors.

When asked what she hoped would come from the whistleblower complaint, she stated she hoped the patients would get high quality nursing and medical care. Ms. Dawson stated they did not deserve the care they were receiving. She stated she has a lot of love for Native Americans and admired many of the local Native families. She has a few close friends that are still employed at BCH and wants them to have the help they need to do their job to provide high quality nursing care for the patients. She stated she would never work for IHS again due to the experiences she had at BCH and Whiteriver. She stated and believed she was treated badly because she complained about bad things going on at work.

3) A summary of any evidence obtained from the investigation:

The investigation focused on the four items of concern as listed in the letter from OSC dated January 23, 2013, regarding OSC File No. DI-12-3553. The findings for the four items are summarized below.

Staff interviewed included staff nurses from the unit in which Ms. Dawson was employed. Staff nurses were from the shift in question as well as other shifts and nursing units, DON, CMO, CEO, Ms. Racine, Ms. Dawson's acting supervisor at the time of the complaint, and hospital security. The interviews were conducted by both Ms. Pratt and CAPT Sabatinos on

day shift. CAPT Sabatinos conducted an unannounced 3 a.m. visit to the inpatient and ER units as well as the security office.

I. Alleged inappropriate Nursing behavior.

1) Sleeping or watching movies while on duty.

In response to Ms. Dawson's complaint, the DON conducted unannounced tours of the unit to assure nurses were not sleeping or watching movies. The DON issued a memorandum to nursing staff on or about February 19, 2012 stating sleeping and watching movies on duty was not acceptable and there would be consequences for staff found sleeping or watching movies while on duty. The memo was re-issued 6/28/2013 to all nursing staff. Ms. Dawson's supervisor, Ms. Racine, also investigated the complaints. Ms. Racine provided a signed statement to CAPT Sabatinos describing the verbal warning she had given to Ms. Flammond, CNA, who Ms. Dawson named in her complaint concerning sleeping on duty. Ms. Flammond has denied that she was sleeping on duty.

Based on an unannounced March 28, 2013, visit by CAPT Sabatinos to the inpatient and ER nursing units at 3 a.m., there was no evidence of nurses sleeping on duty or watching movies during the night shift. There were also no reports of sleeping or movie watching from non-nursing staff interviewed for this investigation; these staff members were able to observe the inpatient nurses on the night shift. Their observations support the findings of this investigation which was nurses were expected to care for a full unit of patients without adequate clerical support, nursing staff, or supervision.

2) Unavailability of nursing staff.

Many nurses did leave the hospital for their one hour lunch going home for this period of time. This absence could potentially result in a need for assistance from a nurse that was physically absent due to being away from the unit on their unpaid lunch time. This break away from the unit coupled with the short staffing and maximal patient occupancy could lead to times of nursing assistance not being available.

3) Failure to record allergic reactions following blood transfusion.

Regulatory and professional organizations, including CMS, the American Association of Blood Banks, and the College of American Pathologists, require ongoing monitoring of blood utilization within institutions. Essential to effective transfusion practices are the implementation of evidence based transfusion guidelines to reduce variability in transfusion practice, and the employment of multidisciplinary teams to study, implement, and monitor local blood management strategies. An interview with Ms. Linda Dusterhoff, QAO indicated that completion of the blood transfusion tag at the time of Ms. Dawson's

complaint was a significant issue. Several nurses did not complete the documentation required on the transfusion tag which included documenting the status of the patient following the administration of the transfusion.

Nine months ago, the QAO developed a new policy to encourage the completion of the transfusion tag. Every unit of blood checked out of the Blood Bank at BCH Laboratory must have an accompanying Blood Bank Slip or transfusion tag. The process is as follows:

- a. A section is filled out by the nurse after the physician gives the order for blood and the slip is sent to the lab.
 - b. The unit(s) are cross-matched and the entire bottom section (below the bolded line) is filled out by the lab staff. In the right bottom corner is where lab staff attach a Key Transfusion number that was taken from the unit that is to be transfused with this slip. This number is sometimes referred to as the R Number because it always begins with an R along with 4 numbers.
 - c. When a nurse comes to pick up the blood from the lab, the lab tech and nurse sign where it says Inspected/Issued by and Received by.
 - d. Before the blood can be started, two nurses must sign below the statement on the top left after filling in the Key Transfusion Number (the R Number) attesting that they have checked to make sure the R number is the same on the recipient's blood band (the Blood ID Band has name, chart number, birthday, and the R number that matches this unit), the unit of blood that is to be transfused, and the Blood Slip itself.
 - e. The nurse will fill in the rest of that section so that when the empty blood bag is removed from the patient, this entire Blood Slip will be completely filled in which is a requirement of Blood Utilization from the Blood Bank.
- The QAO was continually monitoring the compliance with this new policy and found improvement over the old system, but not 100 percent. Of the transfusion tags, 5 percent continue to be incomplete. It was found that the QAO was reviewing each incomplete tag and working with the Nursing Department to complete the tags prior to permanent filing. Based on the finding of incomplete tags, the QAO provides one-on-one training for nurses who do not complete the required documentation on the transfusion tag, in addition to training for all nursing staff already in place. This is an on-going Quality Improvement Project.

- 4) Administering unnecessary medications to promote sleep providing for long breaks.

The pharmacy and CAPT Sabatinos conducted research into the Pyxis archived information for the administration of Ativan during the period of July 2011 to March 2012 by the two nurses named in the complaint. The review found no evidence of medication given to promote sleep. Following each administration of Ativan there was documented reassessment of the patient's condition.

II. Hospital employees propping open security doors.

The door in question, for this item and item III, was an exterior full glass door with a vestibule which was located approximately forty feet from the nurse's station. The door opened directly from the back parking area into the combined nursing unit which served inpatient, obstetrics, and newborn patients. The door was reportedly to be locked at 9 p.m. and unlocked at 5 a.m. each day.

A sign had been affixed to the door indicating that visiting hours are over at 8 p.m. and anyone wanting to enter when the door was locked needed to use the ER entrance and be escorted by security. This sign had been repeatedly torn down and currently was not posted.

Interviewees indicated that daily there were visitors and family members pounding on the door when the door was locked who expected to be granted entrance. There reportedly was no policy governing access of visitors and family members after visiting hours. In response to the pounding on the door, the nurses would respond and physically open the door if the individual stated they were a family member or visitor of a patient on the unit. The nurses were very concerned about not opening the door as the visitors and family members became irate and belligerent if denied immediate entrance.

The nursing staff was very concerned about the lack of a unit access policy and the easy exterior access to the inpatient, obstetrics, and newborn units at all hours of the day and night. The nurses stated they did not prop open the door as they were very concerned about someone coming in and "blowing them all away," seeking drugs, or retribution for a patient being cared for on the unit. According to the staff, their concern did not prevent visitors and patients from propping open the door which did occur. The nurses would not be able to notice propping of the door from the nurse's station unless they actually went to the door and examined it. There was no security camera on this door.

III. Hospital employees smoking and permitting patients and visitors to smoke on IHS property.

This item referred to the glass door and the associated vestibule as described in item II. Directly outside this door there were two eight foot wooden benches. CAPT Sabatinos observed the benches during five visits to the inpatient unit at different times of the day, afternoon and night and noted that during four of the five visits there were one to four individuals sitting on the benches smoking. The smell of cigarette smoke was present in the hallway leading to the nurse's station. CAPT Sabatinos did not identify the status of the individuals that were smoking as whether they were an employee, visitor, or patient.

The nurses stated on a daily basis that staff, patients, and visitors did smoke directly outside the door and the smell of cigarette smoke did come into the unit occasionally. They also noted that patients or visitors may prop open the door after it was locked so they can return to the ward after they finished smoking. CAPT Sabatinos also noted many cigarette butts at the ER and main entrances to

the hospital. The CEO stated prohibiting smoking was difficult as the "Tribe" feels this was their hospital and if they wish to smoke they would smoke.

IV. Failure to maintain/repair exterior security lighting.

CAPT Sabatinos visited BCH at 3 a.m. to verify the current status of exterior lighting. All four foot tall light poles surrounding the front and ER entrance of the hospital were off. The ER front entrance canopy had multiple lights that were not working. Ten hospital-owned street pole lights adjacent to the driveway to the ER employee parking area, the ambulance garage, and the rear inpatient parking were not working. Four of five wall-mounted high intensity lights above the ambulance garage and other doors were not working. One street pole light located by the ER employee entrance was reportedly knocked down two winters ago and was still lying behind the ER. The area of the ER employee entrance parking area and ambulance garage were essentially black with no adjacent ambient lighting.

All hospital front parking lot lights were lit as well as all street and rear pole lights in the housing areas were lit.

Ms. Dawson alleged the hospital security did not patrol. This was found to be accurate. Hospital security was a Public Law 638 contracted service from the Blackfeet Tribe. Security did not patrol providing service within the hospital building. The police were Tribally contracted with the Bureau of Indian Affairs and were responsible for all patrol services of neighborhoods including IHS government housing.

Hospital security and monitoring capacity was fragmented. The hospital building contained the IHS hospital, clinic, ER, and the Tribal residential alcohol treatment program (ATP). Both the hospital and ATP security programs were tribally operated. It was reported that the ATP had an eighteen camera monitoring system that included multiple exterior cameras, for the portion of the building that was exterior to the ATP, as well as interior cameras. All of these cameras had zoom and audio capacities with immediate recording capability. The cameras were monitored by a health technician who contacted the hospital security in the event of an incident requiring security support.

The hospital complex had eight cameras with no exterior capacity, no zoom, no audio and no immediate record capability. It was reported that the security staff had no access to the monitoring equipment servers between 4 p.m. and 8 a.m. for rebooting and other technical issues. The equipment was located in the original security office located in the ER, which was repurposed into the ER Nurse Manager's office. Only the ER Nurse Manager had the key to this office. The security staff had no access to the internet for the filing of Webcident reports.

The hospital security response was found to be inconsistent. Nurses reported a significant variability in response time in calls for assistance to the unit based on the security employee on duty. Variability would be as long as thirty minutes and sometimes included a very belligerent attitude for being called.

4) Listing of any violation or apparent violation of law, rule or regulation:

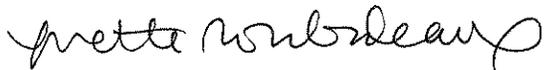
- A. Violation of IHS, Division of Epidemiology and Disease Prevention, IHS Tobacco Free Policy §4.

5) A description of any action taken or planned as a result of the investigation:

A. Changes in agency rules, regulations or practices:

1. Availability of Nursing Staff.
 - a. Facility memorandum regarding official breaks was re-issued (Attachment 2).
 - b. The DON developed a policy regarding Minimum Staffing Levels during Shift and Meal Breaks (Attachment 3).
 - c. Nursing Orientation Policy, Blackfeet Community Hospital Orientation Checklist and Registered Nurse Orientation Checklist (Attachment 4).
 - d. Charge Nurse Assignment Policy (Attachment 5).
2. Failure to properly record patient reactions following blood transfusions.
 - a. Blood Utilization Review – Blackfeet Service Unit Policy No. 01-11-042. Policy has been implemented and all staff involved in administration of blood products and documentation required. QAPI Nurse has conducted continuous reviews of lab data sheets to assure compliance with policy. (Attachment 6).
3. Administering unnecessary medications to promote sleep.
 - a. Physician Order Review 24 Hour Chart Check Policy (Attachment 7).
 - b. Medication Administration Policy (Attachment 8)
4. Hospital employees propping open security doors.
 - a. Patient Visitor policy has been developed to identify visitor hours. Magnetic lock and alarm have been installed on security door. Policy approved October 28, 2013 (Attachment 9).
5. Hospital employees smoking and permitting patients and visitors to smoke on IHS property.
 - a. Smoking policy has been revised and implemented. The new policy has instituted a non-smoking campus. A meeting was held with the Blackfeet Tribal Health and Blackfeet Tribal Council to inform them of the intended implementation of Policy for Tobacco Free/No Smoking and to request assistance in informing the public (Attachment 10).

6. Failure to maintain/repair exterior lighting.
 - a. The repair of exterior lights at the BCH facility was completed on July 31, 2013.
7. Alleged Inappropriate Nursing Behavior .
 - a. Facility Memorandum regarding staff sleeping during their tour of duty was re-issued (Attachment 11).



Yvette Roubideaux, M.D., M.P.H., Acting Director, IHS

Attachments (11)

Attachment 1

PERMERICA.COM PRESENTS:
THE BEST OF SOELR 2003
Los Angeles, California

ADMINISTRATIVE INVESTIGATIONS

PART 1

What is an administrative investigation?

Any agency investigation that is not conducted for the purpose of law enforcement or criminal prosecution.

What is the purpose of an administrative investigation?

Gather the facts. Most generally, the purpose of an administrative investigation is to provide a factual basis for choosing a course of action. An investigation is most commonly undertaken when there is some prospect of legal action to follow, as in the case of an EEO complaint or an appeal to the Merit Systems Protection Board.

In the case of a pre-action investigation, the purpose is to support the decision to take or not take disciplinary action. Accurate information serves the valid interests of the manager and the subject employee.

The goal is to impartially gather and compile all relevant evidence. Some reports of investigation are intended to include a recommendation for action.

Establish credibility. Good investigation also establishes a careful decisional process to support the validity of the management decision. Many good and correct management decisions have been undermined at trial by evidence of biased, sloppy, or incomplete investigation. The hearing officer, judge, or jury may believe that if the investigation was poor, the resulting decision must also be poor. Also vice versa.

What legal rights does the agency have to perform investigations?

Right to manage workforce and take appropriate disciplinary action implicit in Civil Service Reform Act.

Requirement to investigate EEO complaints – 29 C.F.R. § 1614.108(b) requires that “the agency shall develop an impartial and appropriate factual record upon which to make findings on the claims raised by the written complaint.”

Inspector General Act of 1978.

What legal rights does an investigator have in collecting information?

Cooperation. The agency and the investigator have a right to full cooperation from all federal

employees. Refusal to cooperate is grounds for action, including removal. *Weston v. HUD*, 724 2d 943 (Fed. Cir. 1983). The MSPB has characterized *Weston* as holding that, "under Board and Federal Circuit precedent, an employee may be removed solely for remaining silent in response to an inquiry if the employee is adequately informed that he or she is subject to discharge for not answering questions and that

any replies and their fruits cannot be employed in a criminal case. See *Weston v. Department of Housing & Urban Development*, 724 F.2d 943, 949 (Fed. Cir. 1983); *Haine v. Department of the Navy*, 41 M.S.P.R. 462,

469 (1989). *Walsh v. VA*, 62 M.S.P.R. 586 (May 31, 1994). See also *Hanna v. Dept. of Labor*, No. 00-3240 (Fed. Cir. 2001), unpublished 18 Fed. Appx. 787.

But removal is not automatic by any means, and the MSPB has also found adequate grounds to distinguish *Weston*, if the facts are right. *Franklin v. DOJ*, 71 M.S.P.R. 583 (Sept. 20, 1996) (Board sustained lesser action than removal for failure to cooperate where agency gave employee only one chance

and failed to advise the employee of the possible consequences of non-cooperation). See also *Modrowski v. Department of Veterans Affairs*, 253 F.3d 1344 (Fed. Cir. 2001).

Truth. The agency and investigator have the right to expect truthful answers during the investigation. False answers or misrepresentations can be the basis for action, including removal. In *LaChance v. Erickson*, the lower Court of Appeals had held that a federal agency could not discipline an employee for providing false information during an investigation. The Supreme Court reversed the Court of Appeals. The Court of Appeals had expressed a concern that if an employee were required to be truthful, they might "be coerced into admitting the misconduct, whether they believe they are guilty or not, in order to avoid the more severe penalty of removal possibly resulting from a falsification charge." The Supreme Court described this concern as "entirely frivolous . . . we hold that a government agency may take adverse action against an employee because the employee made false statements in response to an underlying charge of misconduct." *LaChance v. Erickson*, 118 S.Ct. 753, 754 (1998) (emphasis added). See also *Cross v. Department of the Army*, 89 M.S.P.R. 62, 80 (2001) (removal of supervisor for falsification during investigation upheld).

Lack of Candor and Falsification. Lack of candor and falsification are different, although related, forms of misconduct, and the latter is not a necessary element of the former. Falsification involves an affirmative misrepresentation, and requires intent to deceive. Lack of candor may include a failure to disclose something that, in the circumstances, should have been disclosed in order to make the given statement accurate and complete. It involves an element of deception, but intent to deceive is not an element. *Ludlum v. Department of Justice*, 278 F.3d 1280 (Fed. Cir. 2002).

What legal rights do the participating witnesses have in the investigation?

Basic introduction. As a matter of courtesy and good investigative practice, the investigator

should always introduce himself/herself and explain that they are conducting an official investigation. The investigator should explain the nature of the investigation and advise an employee-witness that participation

is mandatory and that a record of the interview will be prepared. It is important to explain that the information provided will not be confidential. It is also a good idea to advise the witness that he or she will be provided a copy of the record of interview.

An employee is not entitled to be informed of the charges made against him or her at the administrative investigation stage. *Ashford v. DOJ*, 6 M.S.P.R. 389 (June 1, 1981).

A non-employee witness cannot be required to participate.

Legal Rights. An employee does not have a right to legal representation unless the investigation may lead to criminal prosecution. If the investigation could be used in a criminal prosecution, the employee has the same rights as any other suspect being questioned. And in the case of a custodial questioning, the employee must be advised of rights under *Miranda v. Arizona*, 384 U.S. 486 (1966) – the right to remain silent, any statement may be used in evidence against him, and the right to the presence of an attorney, retained or appointed. Criminal investigation is beyond the scope of this outline and should be referred to the proper law enforcement authority. If an employee has reason to believe that information that he or she provides could be used in a criminal prosecution, they do not have to cooperate with the administrative investigation and cannot be disciplined for refusing to respond. *Gardner v. Broderick*, 392 U.S. 273 (1968).

Important note: The fact that an employee can refuse to participate in an investigation even though he or she is suspected of wrongdoing can be a major problem and is addressed below in detail.

Right to a Union Representative. 5 U.S.C. § 7114(a)(2)(B). If an employee is within a bargaining unit, has reason to believe the investigation could lead to disciplinary action, and requests union representation, the union then has a right to send a representative to be with the employee at the investigation. The union/employee may also have additional rights under contract or past practice.

5 U.S.C. § 7114(a)(2)(B) reads in part: "an exclusive representative of an appropriate unit in an agency shall be given the opportunity to be represented at any examination of an employee in the unit by a representative of the agency in connection with an investigation if – (i) the employee reasonably believes that the examination may result in disciplinary action against the employee; and (ii) the employee requests representation." This language is based on *NLRB v. Weingarten, Inc.*, 420 U.S. 251 (1975).

Bargaining Unit Only. Unlike the private sector where *Weingarten* rights have been extended to unrepresented employees, only federal employees in appropriate units are covered by § 7114(a)(2)(B). The right to union representation has four parts:

- (1) meeting must constitute an "examination,"
- (2) in connection with an "investigation,"
- (3) the employee must "reasonably believe" that discipline could result, and
- (4) the employee must request representation.

Examination in connection with an Investigation: Broadly defined by the FLRA. The rule of thumb is

if the agency is seeking information from the employee then it is an examination in connection with an investigation; if the agency is simply giving information to the employee, it is not an examination. *AFGE, Local 2366 v. INS, U.S. Border Patrol*, 46 FLRA 31 (Oct. 28, 1992); and *AFGE Local 1138 v. Wright Patterson Air Force Base*, 9 FLRA 117 (Aug. 5, 1982) (meeting for the sole purpose of informing an employee of a decision already made by the agency is not an "examination.") Inspector General investigators are agency representatives and this extends to criminal investigations by agency investigators as well. *National Aeronautics and Space Administration, Washington, D.C. Office of the Inspector General v. FLRA*, 119 S. Ct. 1979 (1999). See also U.S. Department of Justice, Washington, D.C. and U.S. Department of Justice, Office

of the Inspector General, Washington, D.C. 56 FLRA No. 87, 56 FLRA 556, 560 (2000)(the relationship between the Inspector General and the agency does not change when a criminal matter is investigated).

Reasonably Believed: This is an objective test whether a reasonable person would conclude that disciplinary action might result. "The FLRA has consistently interpreted 7114(a)(2)(B) to say that a right to union representation exists whenever the circumstances surrounding an investigation make it reasonable for the employee to fear that his answers might lead to discipline. The possibility, rather than the inevitability, of future discipline determines the employee's right to union representation." AFGE, Local 2544 v. FLRA, 779 F.2d 719 (D.C. Cir. 1985). Remember this right is present even if management is not intending any discipline at the time of the examination, and it is present even if another employee is the subject of the investigation.

Request for Representation: There is no specific form in which the request must be made. If the employee places the agency on notice of his or her desire for union participation, that is sufficient. *Tidewater Virginia Federal Employees Metal Trades Council v. Norfolk Naval Shipyard*, 35 FLRA 116 (May 10, 1990). There is no statutory requirement to advise the employee of the right to request union representation, but many collective bargaining agreements do include that right by contract.

Agency Choices: Once an employee has requested a union representative, the employer has three options:

- (1) grant the request,
- (2) cancel the interview, or
- (3) offer the employee a choice between continuing without representation or having no interview at all (if employee chooses to continue, the right to representation is waived).

Choice of Representative. The union chooses the representative. However, the presumption that the union selects the representative can be rebutted where the agency can demonstrate "special circumstances" that preclude that representative -- agency must show that the integrity of investigation would be compromised.

Waiting for Representative. If there is an undue delay, the agency may resume the interview, but that is risky. The FLRA has indicated that it is "unwilling to conclude that there is never any obligation to postpone a Weingarten interview merely because a specific union representative is not available." AFGE, Local 1917 v. INS, 46 FLRA 114 (Jan. 15, 1993). Factors the FLRA will consider are: (1) was delay caused by agency, (2) availability of other capable representatives, and (3) impact of postponement on investigation.

Representative's Conduct. The role of the union representative is not entirely clear. The FLRA has indicated that the employer is free to insist on hearing the employee's own account and the representative cannot speak for the employee. Beyond that the FLRA has allowed the representative to be active in assisting the employee. This has included demanding the interviewer clarify questions to the employee, taking an active role in helping the employee present facts in his defense, and the right to "consult privately" with the employee outside the hearing of the interviewer. AFGE, Local 171 v. Bureau of Prisons, 52 FLRA 43 (Oct. 23, 1996).

Right to Information. The union representative can ask for pre-interview information. There is no general right to discovery and the agency need not reveal its case or the information already obtained.

The union is entitled to general information to become familiar with issues and effectively assist the employee.

Remedy for Failure. Failure to abide by 7114(a)(2)(B) rights may invalidate any subsequent

disciplinary action. In a case in which the FLRA found a Weingarten violation by the employer, it ordered the interview of the employee be repeated "at the request of the union and the employee, with appropriate union representation, and that the disciplinary action previously taken against the employee be reconsidered based on information obtained in the new interview without reference to or reliance on information obtained in the previous interview." The FLRA also ordered the employee be "made whole" consistent with the new disciplinary action. *AFGE Council of Prison Locals v. Federal Bureau of Prisons*, 55 FLRA 64 (Apr. 29, 1999). See also, *AFGE, Local 2313 v. Bureau of Prisons, Safford, AZ*, 35 FLRA 56 (Apr. 6, 1990).

Brookhaven: Re-Interview in preparation for Hearing. A special rule applies when the employer desires to interview or re-interview an employee in preparation for a third-party hearing, such as preparing for arbitration. The FLRA has directed:

- (1) management inform the employee who is to be questioned of the purpose of the questioning, assure the employee that no reprisal will take place if he or she refuses, and obtain the employee's participation on a voluntary basis;
- (2) the questioning must occur in a context which is not coercive in nature; and
- (3) the questions must not exceed the scope of the legitimate purpose of the inquiry or otherwise interfere with the employee's statutory rights."

Internal Revenue Service, Brookhaven Service Center and National Treasury Employee Union, 9 FLRA 132 (Aug. 16, 1982). The FLRA does a case-by-case review of Brookhaven issues to determine "voluntariness."

How does an Investigator avoid the problem of the employee's right to remain silent?

The Supreme Court concluded that an employee cannot be dismissed because he or she has refused to answer questions about on-the-job conduct if they have invoked their Fifth Amendment rights to remain silent.

Similarly an employee cannot be disciplined for refusing to waive his or her Fifth Amendment rights.

Gardner v. Broderick, 392 U.S. 273 (1968) and *Sanitation Men v. Sanitation Commissioner*, 392 U.S. 280 (1968). "If answering an agency's investigatory question could expose an employee to a criminal prosecution, he may exercise his Fifth Amendment right to remain silent. See *Hale v. Henkel*, 201 U.S. 43, 67, 26 S.Ct. 370, 376, 50 L.Ed 652 (1906)." *LaChance v. Erickson*, 118 S.Ct. 753, 754 (1998).

Problem. Since many types of on-the-job misconduct can include a potential for criminal prosecution, this can impede an investigation. For example, a complaint of sexual harassment may include an offensive touching that is arguably an assault and battery offense. Or, you may have an argument that ended in shoving or even fighting; this is also a potential criminal offense. If the investigator needs to gather information from the suspected offender, the problem of the employee having the right to remain silent is often significant to the investigation.

Unless the information is going to be used for criminal prosecution, there is no right to remain silent. *Kalkines v. United States*, 473 F.2d 1391 (Ct. Cl. 1973).

The MSPB has interpreted *Kalkines* to support the proposition that an employee can be removed for failing to reply to investigatory questions:

An employee may be removed for not replying to questions in an investigation by an agency if he is adequately informed both that he is subject to discharge for not answering and that his replies and their

fruits

cannot be employed against him in a criminal case. See, e.g., *Kalkines v. United States*, 473 F.2d 1391, 1393, 200 Ct.Cl. 570 (1973).

Haine v. Navy, 41 M.S.P.R. 462 (Aug. 9, 1989). In this case the employee had received proper warning advice, including:

- (1) He would be asked questions concerning the performance of his official duties;
- (2) he had a duty to reply to these questions;
- (3) neither his answers nor any information or evidence therefrom could be used against him in a criminal proceeding; and
- (4) he would be subject to dismissal if he refused to answer or failed to respond truthfully and fully to any questions.

But even if an employee is not fully warned, the right to remain silent only applies if the employee has a reasonable basis to believe that criminal prosecution could result. *Ashford v. DOJ*, 6 M.S.P.R. 389, 466 (1981).

If an employee is forced to answer incriminating questions under penalty of disciplinary action, the answers cannot be used in a criminal proceeding. *Garrity v. New Jersey*, 385 U.S. 493 (1967).

Warning re: *Garrity plus Kalkines*. Some guides to administrative investigations have put *Garrity* and *Kalkines* together and come to a problematic conclusion. The analysis goes like this: (1) since evidence obtained from mandatory questioning cannot be used in a criminal prosecution pursuant to *Garrity*, then (2) pursuant to *Kalkines* the employee must answer or face disciplinary action for failure to cooperate.

In essence the two rules work together as a de facto "use immunity" and this then requires an employee to answer investigatory questions or face discipline, possibly removal.

Important note: This is legally correct. See *Bucknor v. U.S. Postal Service*, 93 M.S.P.R. 271 (2003) (separate opinion by Judge Slavet). But if the de facto immunity results in damaging a federal or state prosecutor's case when it goes to criminal trial, it will be very embarrassing for the agency and investigator. To avoid this problem, the Department of Justice has established very clear rules prohibiting agencies from unilaterally giving an employee "use immunity."

Under no circumstances should a prospective interviewee with foreseeable criminal exposure be interviewed under an express or implied threat that he will be discharged if he refuses to cooperate in the investigation by invoking his rights under the Fifth Amendment, unless this course of action has been discussed with and approved by the Department of Justice. Requests for permission to utilize this interrogation procedure should be directed to the Justice Department component to which a referral of the matter would be made pursuant to 28 U.S.C. 535. Such clearance should be obtained before the witness is questioned.

Attorney General Memorandum to Agency Heads dated June 4, 1980. The authority to grant use immunity is specified by regulation and the U.S. Attorneys' Manual. 28 C.F.R. § 0.175. U.S. Attorney's Manual Chapter 9-23.140. An agency can provide use immunity under limited circumstances "with the approval of the Attorney General." 18 U.S.C. § 6004. No agency has the authority to approve or cause a grant of use immunity on its own authority.

When an agency undertakes an investigation of an employee for matters that have potential criminal liability, it has two choices:

1. Give the employee a Miranda type warning that includes the right to elect to remain silent.

2. Get a clearance from the Department of Justice to allow the witness "use immunity" and include the language described above in the advice to the witness. For very routine matters, a blanket authority can be approved in advance.

The alternative warning forms are attached. Please remember: Matters that have any real chance of criminal prosecution should be referred to the proper criminal investigative activity.

Finally on the issue of potential criminal prosecution, under no circumstances should an agency representative ever state or imply that criminal prosecution either will or will not be undertaken. Those decisions are in the exclusive domain of the Department of Justice or state and local prosecutors. An implied "transactional immunity," even if made completely without authority, can cause significant problems for prosecutors.

Bottom Line: If an employee is properly warned that disciplinary action may result for lack of truthful cooperation and that any evidence obtained cannot be used in a criminal prosecution, then he or she must truthfully cooperate or face disciplinary action, up to and including removal. *LaChance v. Erickson*, 118 S.Ct. 753 (1998); *Kalkines v. United States*, 473 F.2d 1391 (Ct. Cl. 1973); *Weston v. U.S. Dept. of Housing and Urban Development*, 724 F.2d 943 (Fed. Cir. 1983). See also *Modrowski v. Department of Veterans Affairs*, 252 F.3d 1344, 1351 (Fed. Cir. 2001) ("invocation of the Garrity rule for compelling answers to pertinent questions about the performance of an employee's duties is adequately accomplished when that employee is duly advised of his options to answer under immunity granted or remain silent and face dismissal.").

What legal rights do third-parties have in the investigation?

A meeting with an employee purely for the purpose of investigating a job related issue is not a formal meeting within the meaning of the Federal Service Labor Management Relations Statute and the union is not entitled to have a representative present at the interview. Contrast 5 U.S.C. 7114(a)(2)(A) and (a)(2)(B).

Who will have access to all or part of the investigation?

A witness in an interview is entitled to a copy of his or her own statement or affidavit.

An EEO Complainant is entitled to a complete copy of an investigation conducted pursuant to 29 C.F.R. § 1614.

An employee for whom discipline or adverse action is proposed is entitled to a copy of all materials relied upon by management in deciding to take that action. 5 U.S.C. § 7503.

FOIA -- Freedom of Information Act -- FOIA is an access statute. It permits any person, whether U.S. citizen or foreign, to seek access to records of the Executive Branch of the Government. Supreme Court: FOIA reflects "a general philosophy of full agency disclosure unless information is exempted under clearly delineated statutory language." *Department of Air Force v. Rose*, 425 U.S. 352, 360-361 (1976). Still, there is a less open policy recently. New Justice Department policy:

Any discretionary decision by your agency to disclose information protected under the FOIA should be made only after full and deliberate consideration of the institutional, commercial, and personal privacy interests that could be implicated by disclosure of the information.

In making these decisions, you should consult with the Department of Justice's Office of Information and Privacy when significant FOIA issues arise, as well as with our Civil Division on FOIA litigation matters.

When

you carefully consider FOIA requests and decide to withhold records, in whole or in part, you can be assured

that the Department of Justice will defend your decisions unless they lack a sound legal basis or present an unwarranted risk of adverse impact on the ability of other agencies to protect other important records.

Compare old (1993) DOJ policy: "In short, it shall be the policy of the Department of Justice to defend the assertion of a FOIA exemption only in those cases where the agency reasonably foresees that disclosure

would be harmful to an interest protected by that exemption . . . If there is little or no harm of the type the exemption is meant to prevent, the exemption should not be applied."

Federal Labor Management Relations Act – Under section 7114(b)(4), an agency's duty to bargain in good faith includes the obligation to furnish an exclusive representative of its employees, upon request, and to the extent not prohibited by law, data meeting the following criteria:

- normally maintained by the agency in the regular course of business;
- reasonably available;
- necessary for full and proper discussion, understanding, and negotiation of subjects within the scope of collective bargaining;
- and not constituting guidance, advice, counsel or training provided for management officials or supervisors relating to collective bargaining.

Pre-Trial Discovery: If the case proceeds so far as federal district court, the rules of pre-trial discovery require the release of all relevant evidence or any information that may logically lead to relevant evidence. Federal Rules of Civil Procedure 26 (b)(1):

Parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action, whether it relates to the claim or defense of the party seeking discovery or to the claim or defense of any other party, including the existence, description, nature, custody, condition, and location of any books, documents, or other tangible things and the identity and location of persons having knowledge of any discoverable matter. The information sought need not be admissible at the trial if the information sought appears reasonably calculated to lead to the discovery of admissible evidence.

Is a Privacy Act Statement required?

Sometimes "yes" and sometimes "no." A good lawyer's answer. If you are collecting information for inclusion in a system of records and those records can be retrieved by name or personal identifier, a Privacy Act Statement is required. In the normal pre-action investigation the information will not be included in a system of records and a Privacy Act Statement is therefore not normally required. By comparison, an IG investigation or an EEO investigation is maintained in a system of records and would require a privacy act statement.

In my experience, most investigators conducting a simple pre-action investigation do not provide a Privacy

Act Statement. But using a Privacy Act Statement is easy enough and can be incorporated into your other advice memorandum under Kalkines. The Privacy Act neither confers nor denies the right to remain silent. Thus as indicated elsewhere in this discussion, if a government employee is required by other regulations to answer questions, he or she cannot refuse to answer questions based on the Privacy Act.

This is another good area to discuss with your legal advisor prior to beginning your investigation.

What about Confidentiality?

Two important issues

First, allegations that lead to investigation usually involve sensitive issues and are almost always derogatory in nature. In short, the mere existence of the investigation may constitute an invasion of privacy, harm the reputation and careers of individuals, and tarnish the image of the agency. The investigator must do everything possible to prevent or minimize the spread of information beyond those who absolutely must know. This is a large part of the need for complete objectivity in the investigation. Keep the files and statements safe, advise all witnesses that they are not to discuss the investigation or their testimony, and do not discuss the investigation outside of those who need to know.

Second, many people who provide information during an official investigation believe their identity and information will be held in strict confidence. But there is no right to confidentiality. Even the Inspectors General Act of 1978 does not provide absolute confidentiality even to the complainant. The investigator must clearly communicate to all the witnesses that the information included in the investigation may be made public in one form or another. Never promise confidentiality.

What about Reprisal?

The right to communicate with your agency and disclose issues of suspected misconduct is protected by the Whistleblower's Protection Act. The scope of this protection is beyond this outline, but every investigator should advise witnesses that if they believe reprisal has or is about to take place because they participated in the investigation, they should immediately contact the investigator. Reprisal is a separately punishable offense under many authorities and may very well constitute a greater violation than what is being investigated. For example, in the EEO area, reprisal against an employee for participation in the EEO complaint process is itself a separate act of discrimination.

When preparing the statement, what format should be used?

I recommend that statements be taken in the form of a declaration rather than an affidavit. An affidavit must be notarized to be properly executed. Whereas a declaration under 28 U.S.C. § 1746 is acceptable in court without notarization.

A simple and effective declaration format is simply:
Pursuant to 28 U.S.C. § 1746, I, _____, declare as follows:
[body of declaration]

I declare under penalty of perjury that the foregoing is true and correct. Executed on ___[date]___ .

_____[Signature]_____

_____[Witness]_____

Federal courts have routinely held that a person who makes a false § 1746 statement "under penalty of perjury" may be charged with perjury under 18 U.S.C. § 1621, just as if the statement were made under oath.

OFFICIAL SHIPYARD INVESTIGATION

EMPLOYEE INFORMATION AND ACKNOWLEDGMENT FORM

Please carefully read and initial each section:

I have been informed and I understand this is an official investigation involving matters relating to my official duties as a federal employee.

I have been informed and I understand, as a federal employee, I am required to cooperate with this official investigation and provide truthful answers.

I have been informed and I understand this is not a criminal investigation and neither the information I provide in response to questions by the investigator or any evidence gained by reason of my answers will be used against me in a criminal proceeding unless I knowingly provide false information.

I have been informed and I understand that if I refuse to cooperate and answer questions in this official investigation, my refusal to cooperate can be a basis for disciplinary action, which may result in my removal from federal service.

___ I have been informed and I understand if I provide information during this official investigation that I know to be false at the time I provide that information, my providing false information can be a basis for disciplinary action which may result in my removal from federal service.

I have been informed and I understand if I provide information during this official investigation that I know to be false at the time I provide that information, my providing false information can be a basis for criminal prosecution.

SIGNATURE TIME & DATE

WITNESS TIME & DATE

OFFICIAL SHIPYARD INVESTIGATION

YOUR RIGHTS AS A WITNESS

1. You have the right to remain silent and refuse to answer any questions at any time.
2. Anything you say or do can be used against you in a court of law or administrative proceeding.

3. You have the right to talk to a lawyer before answering any questions and to have a lawyer with you during questioning.

4. If you cannot afford a lawyer, one will be appointed for you without cost before questioning.

5. If you decide to answer questions now, you have the right to stop answering questions at any time.

6. If you refuse to answer questions on the grounds that the answers may tend to incriminate you, you cannot be removed solely for remaining silent.

7. If you choose to answer questions, you must answer truthfully. If you knowingly give false or misleading information you are subject to disciplinary action that may result in your removal from federal service.

I have read each of the seven statements of rights and advice listed above and I understand these rights. I am willing to make a statement and answer questions. No promises or threats have been made against me, and I agree to answer questions of my own free will.

PRINT FULL NAME

SIGNATURE TIME & DATE

WITNESS TIME & DATE

VOLUNTARY STATEMENT

I, _____ make the following voluntary statement to _____ who has advised me that he/she is conducting an official investigation regarding _____. I am making this statement without threat or promise and of my own free will.

OR OFFICIAL STATEMENT

I, _____ have been advised that I am required to provide a truthful statement regarding official duties. I make this statement to _____ who has identified herself/himself as conducting an official investigation into _____.

I make this statement as part of my official duties and it is truthfully made without threat or promise.

OR AFFIDAVIT

I, _____ hereby certify under penalty of perjury, in accordance with 28 U.S.C. § 1746, that the following is true and correct to the best of my belief.

CLOSING PARAGRAPH

By my signature below I acknowledge that I have read and understood my statement consisting of this page and _____ other pages. I have made all the changes and corrections I desire to make and have initialed each change I have made.

Signature and date [Witnessed, sworn to, or notarized]

OATHS

An oath is not required, but can provide support in getting truthful statements. It is important to get all statements in writing, signed, and witnessed for authenticity. An unsworn declaration pursuant to 28 U.S.C. § 1746 is acceptable as evidence under federal district court rules, and I have never had an administrative agency refuse one.

Several statutes give federal employees the authority to administer oaths or you may be able to have the witness sign the document in front of a notary public. The most general authority is 5 U.S.C. § 303. It reads:

(a) An employee of an Executive department lawfully assigned to investigate frauds on or attempts to defraud the United States, or irregularity or misconduct of an employee or agent of the United States, may administer an oath to a witness attending to testify or depose in the course of an investigation.

(b) An employee of the Department of Defense lawfully assigned to investigative duties may administer oaths to witnesses in connection with an official investigation.

PART II

PLANNING, CONDUCTING, AND REPORTING INVESTIGATIONS

Planning the Investigation

Know your Task and Authority

What information is being sought and why?

What degree of importance?

Are there any pre-investigatory restraints?

What are the deadlines?

Assess your Own Impartiality and Objectivity

Assess your Knowledge of the Subject

Enlist your Subject Matter Experts and Legal Advisor

Consider and List the Objectives of a Complete and Thorough Investigation

Consider your Sources of Evidence

Evaluate the Quality of Evidence

Material Evidence--Evidence is material if it relates to one or more of the issues raised in the inquiry.

Relevant Evidence--Evidence is relevant if it tends to prove or disprove a material issue raised in the inquiry.

Reliable Evidence--Even if material and relevant, not all evidence is worthy of belief. Some factors to consider in determining whether testimony is reliable are:

1. Is the testimony based on personal knowledge or experience?
2. Is the testimony a direct observation or merely a conclusion?
3. Does the witness have an interest in the outcome of the inquiry?

4. Is the witness biased for other reasons?

Prepare an Investigative Plan and Order of Interviews

Order of Preferred Interview Methods

1. In person and face-to-face.
2. Telephone Interview with subsequent written declaration.
3. Written Interrogatories as last resort.

Conducting the Investigation

Collect Most Reliable Information First

Documentary Evidence – Daily Reports, Letters, Logs, Emails, Written Work, Photographs, Video Tape,

Time Cards, Attendance Records, etc.
Neutral Witnesses

Interested Witnesses

Complaining Party and Suspected Employee-- (Remember the Waters and Dong cases)

Method of Interview

1. Tell the witness who you are and the general purpose of the official investigation.
2. Advise the witness of their rights and duties in the investigation (varies).
3. Advise the witness that a written declaration/affidavit will be prepared and they will receive a copy of the completed document.
4. Advise the witness that as you speak to all the witnesses, you will be coming back to seek additional input. Make sure the witness knows there will be follow-up.
5. Advise the witness that you are going to ask them to first tell you everything they know about the issues and that you will then go back through the testimony carefully and ask questions.
6. Ask the witness to narrate what they know about the issues once all the way through. Some experienced investigators choose to take no notes the first time as a way of keeping the witness at ease. The investigator may need to do some prompting, as in "tell the whole story." During free narration, interviewees frequently provide valuable clues while talking about things that would have seemed unrelated to the investigator prior to the interview.
7. Then ask questions and take verbatim notes. Keep the pace within what you can transcribe. Tape recording is an option, but many witnesses are inhibited by a taping device.
8. Many experienced investigators ask easy questions first on issues that are already well established, then move to the more difficult issues. You might think of this as asking direct questions first and then cross-examination questions at the end. Leave the issues most likely to be in dispute until the end.
9. Clarify everything!! Avoid all conclusory statements by the witness. You don't want to know that a person was angry; you want to know what they did, what they said, how they said it, was it a loud voice or a screaming voice, etc. Likewise words like drunk, confused, impolite, disrespectful, late, troublemaking, numerous, threatening, frequent, etc. are all too imprecise and capable of later revisions. Pin down the facts. Never accept a vague statement -- all too often a witness will put a different spin on that statement later. If a comment is capable of more than one meaning, break it down further until it is as singular as possible.
10. Put the interview into a first person statement using the exact words used by the witness (do not edit or summarize in your own language).
11. Have the witness read it, make changes, and sign it. If you can do it in one sitting, with a laptop computer for example, that is the best approach. Administering an oath is optional.
12. Tell the witness to contact you immediately if they think of any new information.
13. When you are done, make sure you know how to contact the witness again and make sure they know how to contact you in the event of newly remembered information.
14. Give the witness a copy of their statement.

15. Advise the witness not to discuss his or her testimony with any other prospective witness.

16. Advise the witness that if they believe there has been any reprisal for their testimony, to contact you immediately.

17. Keep all your original notes with the finished statement.
Conduct to Avoid

1. Showing personal prejudice or bias to witness.
2. Lying.

3. Hurrying.

4. Degrading the witness.

5. Placing too much value on minor inconsistencies.

6. Bluffing.

7. Anger.

8. Leading questions – most people are suggestive and want to please the interviewer;

do not suggest the "right" answer.

9. Negatively phrased questions – such as, "You wouldn't do anything like that, would you?" Again, this not only suggests the "right" answer, it communicates that the investigator has already prejudged what will be reported as wrongdoing. The investigator should not influence the testimony.

10. Compound questions – when questioning, try to ask for one piece of information at a time.

11. Complex questions – keep it simple.

Interview suggestions

Probe for bias or influence – Ask witnesses what they heard about the investigation, whether anyone has discussed it with them, and what, if anything, they have done to prepare for the interview. Ask if any prior testimony has been related to them, and whether anyone has asked them what they would say to the investigator, or has attempted to suggest what they should say. Ask if they have any special relationship to any of the parties (related by blood or marriage, golf partners, members of same club, church etc.). Ask if there is any reason they cannot be fully objective, or if they have any reason to fear reprisal for their testimony.

If you strongly suspect a witness is lying you may give the following advice:

I consider it my duty to advise you that under the provisions of Section 1001, Title 18, United States Code, whoever in any matter within the jurisdiction of any Department or Agency of the United States knowingly and willfully falsifies, conceals, or covers up by trick, scheme or device, a material fact, or makes any false, fictitious, or fraudulent statement or representation, shall be fined not more than \$10,000 or imprisoned for

not

more than five years, or both. Additionally, any person who willfully and contrary to his/her oath testifies falsely, while under oath may be punished for perjury in accordance with Section 1621, United States Code.

Do you understand?

Review all the Evidence Collected

Re-Interview Witnesses as Needed and it probably will be needed

Organize your Evidence

Preparing the Report of Investigation

Subject

Background

List of Exhibits or Enclosures including written witness statements

Statement of Facts (each fact must be supported by one or more Exhibit)

Investigator's Conclusions

ADMINISTRATIVE INVESTIGATIONS
Presented by Dave Franey and Steve Seaton at SOELR

EMAIL FED HR COMMENTS TO: SULLINS@MAIL.VA.GOV

.....
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(federal personnel law)

...>

Attachment 2



DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service
Indian Health Service Hospital
PHS Indian Hospital
Browning, Montana

59417

February 8, 2012

TO: All Supervisors, Blackfeet Service Unit
FROM: Chief Executive Officer, Blackfeet Service Unit
SUBJECT: Breaks (Re-issue)

The intention of this memo is to reiterate the policy regarding official breaks.

Employees are allowed one 15-minute break in the morning and one 15-minute break in the afternoon. The 15 minutes must be used at one time on one break; they cannot be broken up into three five-minute breaks or 15 one-minute breaks, etc. Breaks must be taken midway between the morning hours and afternoon hours of the shifts. They cannot be "saved" for the end of the day or to make up for tardiness. You may not request or receive compensation for the break if you do not use it. Breaks occur during DUTY TIME (you may not leave the premises) and are a privilege.

Managers are required to allow lunch breaks of not less than 30 minutes or more than sixty-minutes. Lunch breaks cannot be taken at the beginning or end of a shift, you may not leave early if you choose not to take a lunch break. Nor may you request compensation for the lunch break if you choose not to take one. Meal breaks occur during NON-DUTY TIME (you may leave the premises) and are a requirement.

As part of the employee's health and wellness program, Management allows employees one-half hour each day to exercise. This exercise time should be used in conjunction with the breaks, i.e. 15 minutes prior to and 15 minutes after the break or around lunch break. This time allowed for exercise may not be used at the beginning of the shift or to depart early. Please keep in mind that exercise time is unofficial and is not an entitlement.

Merlin Gilham

cc: file
NFFE Local #2017

Attachment 3

**INDIAN HEALTH SERVICE
BLACKFEET COMMUNITY HOSPITAL**

SUBJECT: Minimum Staffing Levels During Shift and Meal Breaks	PAGE: 1 of 1
DEPARTMENT: Inpatient Unit (Medical/ Surgical/ Pediatric/ Labor & Delivery and New born Care)	ORIGINATED: 5/14/2013
APPROVED BY: Nursing Administration	Reviewed:

PURPOSE: To establish minimal staffing patterns at on the Inpatient Unit Blackfeet Community Hospital.

- **BACKGROUND:** The Blackfeet Community Hospital Nursing Administration requires inpatient unit to maintain minimum nurse –to-patient staffing ratios.

POLICY:

- A. Minimum staffing ratios:** The policy and staffing plans specify minimum nurse-to-patient staffing ratios that must be maintained at all times – including during meals and other breaks
- **Unit- specific ratios:** There will be a minimum of three RN's on shift at all times when there is a laboring patient or other 1:1 nurse to patient care on the inpatient unit
 - **Regulation use of unlicensed staff –** Unlicensed staff is not to be considered backup for an RN and will not be allowed to perform licensed nursing skills/functions such as medication administration, venipuncture and other invasive procedures.
 - **RN Staffing for Scheduled Breaks –** There will be a minimum of two RNs on the inpatient unit at all times. Not more than one RN will be permitted to go on break at any given time.
 - **Break Schedules –** Breaks will scheduled by the charge nurse assigned to each shift and will be determined by patient care census and acuity.

Attachment 4

INDIAN HEALTH SERVICE BLACKFEET COMMUNITY HOSPITAL

SUBJECT: Nursing Orientation	PAGE: 1 of 1
DEPARTMENT: Nursing Departments	ORIGINATED: 3/90
APPROVED BY: Nursing Administration	Revised: 9/12

POLICY:

All new nursing staff members shall be provided a general orientation to the Blackfeet Community Hospital and a more specific orientation to the assigned patient unit.

PURPOSE:

The nursing department acknowledges that an adequate orientation of all new employees provides an atmosphere conducive to quality patient care and a basis for communication and effective interpersonal relationships with other staff members and patients. An adequate orientation also is essential in assisting the new staff member to feel welcome and eager to provide quality patient care at Blackfeet Community Hospital.

PROTOCOL:

The general orientation program will be for 2 weeks to 3 months or longer depending on experience. The time frame will be considered on case by case basis and with input from the supervisor and the new hire based on their experience and comfort level.

A hospital wide orientation will initiate the orientation process. All departments will be identified and each one's role in providing quality patient care is briefly discussed.

A detailed orientation packet will be given to the new staff member. The orientation packet with all necessary signatures and dates is to be returned at the completion of the orientation.

A skills checklist is provided to each new staff member. The checklist is to be signed, dated and returned to the nursing supervisor at the completion of the orientation. These materials will be filed in the employee's file.

The supervisor of the assigned patient unit is responsible for the specific unit orientation.

Date of origin: 3/90
Reviewed: 3/91 VZ
Reviewed: 8/91 DPT
Reviewed: 2/94 MW
Revised 9/00 MER
Revised 8/03 KC
Revised: 9/12 MG

BLACKFEET COMMUNITY HOSPITAL ORIENTATION CHECK LIST

Procedures: All employees are responsible for attending orientation on each Monday of the pay week. Please put your name in the box below and your department and follow the Priority listed below. The Priority list is to be used as a guide.

Name:		Department:	
DEPARTMENT	✓	Orientation Topic	Initial
Priority 1 Human Resources: Lynette Trombley		Hospital Mission/Vision	
		EOD Paperwork	
		Fingerprints	
		Picture ID Badge/Return	
		Direct Deposit	
		Thrift Savings	
		Retirement	
		Social Security	
		Insurance: Health/Life	
		Bond Deductions	
		Promotion/Step Increases	
		Code of Conduct	
		Staff Rights	
	My Pay		
	Information Packet		
Priority 2 Administration Stacey Costel		Telephone survey/procedures	
		Non Ben policy	
		Complete application for medical services & forward to patient registration	
		Parking	
Priority 3 Community Health Nursing PHNs	✓	If current immunizations	1. List and add any Update's to medical chart. 2. Print IZ record from chart and give to employee for CHNs & Staff safety rep.
		Hepatitis B	
		Tetanus/Diphtheria	
		Measles/Mumps/Rubella	
		PPD, Influenza	
		Update medical chart	
Priority 4 Health Information Management Helen Butterfly		HIPAA/Privacy Act/Confidentiality	
		Completion of MR & CMS timelines for record completion	
		Signature on File/License number	
		PCC Codes	
		Transcription access & code assignment	
		Attestation Statement	
Priority 5 Supervisor		Computer Access Code	
		System Rights	
Site Management		Security/Confidentiality	
Priority 6 Clinical Applications Coordinator Purnee Brandvold		Electronic Health Record Overview	
		Security Keys	

Safety Jeff Severn		EOC Management Plans	
		Safety Brochure Overview	
		Haz/Communication H/O	
Employee Health and Infection Control Jeff Severn		Data-base/Immunization Needs	
		Work Restriction Guidelines	
		Staff With Infectious Disease	
		Importance of Immunizations	
		OSHA Bloodborne Pathogens	
		Standard Precautions	
		TB Training Requirements	
Administration Wanda Lahr		Leave	
		Timekeeping	
Employee Info Betty Williamson		EEO	
Administration Bobbi Lucke		Compliance policy	
Administration Linda Dusterhoff		Narcotic Policy	
Business Office		Application for 3 rd party billing	
Union Tom Connell		Union Structure and Membership	
Cultural Representative		Blackfeet Culture	
Breastfeeding Initiative		Signed page from Baby Friendly Breastfeeding Initiative	

**Blackfeet Community Hospital/IHS
Inpatient Unit
Registered Nurse Orientation
Permanent Full Time Employee GS-610-4/5/7/9**

Name _____

Start Date _____

ORIENTATION TOPIC	DATE COMPLETE	SIGNATURE
Orientation process		Supervisor
Mission/Vision Statement		
Copy of license and certifications		
Schedule		
Time sheets		
OT/CT		
Requesting leave		
Report start times		
Supervisor call schedule		
Lines of Authority		
Staff meetings		
Position description/duties		
PMAPs		
Dress code		
Tour of unit		
Time sheets		Ward Clerk
OT/CT sheets		
Call back schedules		
Call back numbers		
Patient Kardex		
Dietary Kardex		
Mailboxes/lockers		
Telephone numbers/paging		
Snack/diet kitchen		
Work orders/procedures		
ADT package in RPMS		
Referral Criteria & Process		Discharge Planner
Services Provided		
Availability of equipment/supplies		

TOPIC	DATE COMPLETE	SIGNATURE
Services provided		Dietician
Nutritional assessment/screening		
Importance of hts/wts		
Referral process/Criteria		
Organization of department		OR
Services provided		
Traffic flow		
Dress code		
Instrument cleaning		
Emergency packs		
Quality control		
Storage of instruments and packs		
Call back procedure/on call		
Patient preparation process		
Documentation requirements		
Post-op responsibilities		
Services provided		Radiology
Procedures requiring preps		
Radiology prep protocols		
Call back procedure/ on call		
Services provided		Physical Therapy
Referral process/ criteria		
Organization of department		
Exercise room rules		
Services provided		Diabetes program
Referral process/criteria		
Organization of department		
Glucometer codes/instruction		
Organization of department		Lab
Call back procedure/on call		
Lab ordering		
Specimen storage		
Blood bank procedures		
Urine dipstick/HCG		
Fecal occult blood		
CBCs		
Urine drug screens		

TOPIC	DATE	SIGNATURE
Services provided		Respiratory Therapy
Home O2 & nebulizer referral process		
Oxygen thereapy: NC/simple masks		
Aerolsol mask		
Pulse oximetry		
Peak flow		
Incentive Spirometry		
Mist tent		
Chest PT		
RSV/Influenza test collection		
Proper documentation		
Organization of ER		ER supervisor
Disaster protocol		
Assisting in ER		
Layout of OB department		OB supervisor
Storage space for supplies/milk		
Infant warmer and setup		
Basic table set up		
Basic fetal heart monitor use		
Timeline expectation of OB orientation		
Role at BCH		Utilization Review & Compliance officer
Compliance/Utilization		
Quality measures		
Documentation		
EHR: Templates (inpatient adult/ pediatric folder) SAS Checks Neuro flow sheet Focus charting Restraints Addendum charting: wound care, iv assessment, and respiratory flow sheet. Care plan Vital sign supplement NAS (newborn) scores		Supervisor:
Introduction		Director of Nursing

Revised 3/7/12 MG; 11/1/2012

Attachment 5

**INDIAN HEALTH SERVICE
BLACKFEET COMMUNITY HOSPITAL**

SUBJECT: CHARGE NURSE ASSIGNMENT	Effective: Reviewed: 11/12
DEPARTMENT: MEDICAL SURGICAL UNIT	
APPROVED BY: NURSING ADMINISTRATION	

PURPOSE:

POLICY:

- It is the policy of the Blackfeet Community Hospital that:
 - The charge nurse shall plan, assign, delegate, coordinate, supervise and evaluate the nursing assignment throughout the shift.
 - The nurse in charge should consider the following when making assignments.
 - The complexity of the patient's condition and the nursing care required.
 - Knowing the scope of practice of the nurse's on the unit.
 - The dynamics of the patient's status, including the frequency with which the need for specific nursing care activities changes.
 - The complexity of the assessment required by the patient, including the knowledge and skills required on a nursing staff member to effectively complete the required assessment.
 - The degree and availability of supervision required by the nursing staff member based on his/her previously assessed level of competency and scope of practice in relation to the nursing needs of the patient.
 - Type of technology required to provide care and special skills required for proper care.
 - Patient's age.
 - Relevant infection control and safety issues.

**INDIAN HEALTH SERVICE
BLACKFEET COMMUNITY HOSPITAL**

- Continuity of care delivery needs.

PROCEDURE:

- In accordance with the above consideration, total patient care nursing is the primary method of assignment.
- Assignments are to be made in writing with the assignments posted by the medical support assistant. The sheets are completed and the acuity tabulated by the charge nurse at the end of the shift. All paperwork is put into the nursing supervisor's mailbox located in the nurse's lounge.
- The charge nurse will communicate with the Supervisor Clinical Nurse of any nursing needs beyond established staff.
- Charge nurse's will ensure all unusual occurrences are reported in Webcident and notify the Supervisor of Clinical Nursing.
- Staff certification will remain in a three ring binder on the Inpatient ward and assist the charge nurse in making assignments, it will be updated as new staff are hired.
- The nurse in charge remains available to provide assistance with patient care as needed while assuming responsibility for a limited patient load as staffing needs indicates.

Reviewed/Revised 11/08 KC
Reviewed: 10/10 KC
Reviewed: 11/12 SS

Attachment 6

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Public Health Service
Health Services Administration
Indian Health Service

BLACKFEET SERVICE UNIT POLICY NO. 01-11-042

POLICY FOR BLOOD UTILIZATION REVIEW

SEC.

1. Policy
2. Background
3. Purpose
4. Procedure
5. Responsibility
6. Authority
7. Supersession

- I. **POLICY:** It is the policy of the Blackfeet Community Hospital/IHS and its Medical Staff that appropriate review of utilization of blood and blood components takes place at least on a quarterly basis.
- II. **PURPOSE:** To clarify and establish a uniform policy for Blood Utilization Review within the Billings Area Indian Health Service (BAIHS). Ensure safe and effective blood usage based on measurable, predetermined performance criteria and to monitor the appropriate usage of blood products.
- III. **BACKGROUND:** Regulatory and professional organizations, including CMS, the American Association of Blood Banks, and the College of American Pathologists, require ongoing monitoring of blood utilization within institutions. Essential to effective transfusion practices are the implementation of evidence-based transfusion guidelines to reduce variability in transfusion practice, and the employment of multidisciplinary teams to study, implement, and monitor local blood management strategies.
- IV. **PROCEDURE:**
 - The PI Coordinator or designee will review 100% of blood usage on a quarterly basis. All blood ordered will be screened by the reviewer for appropriateness based on provider approved clinically valid criteria.
 - A detailed review of statistical information will be obtained from the Blood Bank portion of the Laboratory computer system and/or the Laboratory department (submitted by the laboratory) on a quarterly basis for the purpose of review, including names and chart numbers of patients receiving blood, whether or not platelets were ordered and given, and any adverse reactions.

- This review must be documented; and may be performed, as is appropriate, through a retrospective patient care evaluation mechanism, medical record review, or any other patient specific reviews.
- The outcome of this review will be reported to the Medical Staff by the QA/PI Coordinator. Any cases referred for Medical Staff Peer Review and deemed to be questionable or deficient, by the assigned provider reviewer, will be referred to the Medical Executive Committee for review and recommendations.
- The assigned provider reviewer must review the blood bank summary on their investigation of actual or suspected transfusion reactions.
- The QA/PI Coordinator must review the quarterly statistics on blood component usage, wastage and ordering practices. These data are systematically aggregated and analyzed on an ongoing basis with the focus on identifying opportunities for performance or process improvement.

AVAILABILITY OF BLOOD

Wasted Blood Products

- The amount of wasted blood products will be tabulated by the laboratory on a monthly (quarterly) basis. A report will be submitted to the QA/PI Coordinator on all cases of blood wastage, identifying what the blood product was and the reason for wastage. This report will be forwarded to the assigned medical staff provider who will review it and make recommendations if necessary. Follow-up of the effectiveness of the action taken will be demonstrated in the reduction on wastage rate for the following reporting period.
- Capability of meeting demand for blood in a timely manner. The Medical Staff will support the established mechanisms that currently exist in the laboratory and the blood bank to assure availability.

Emergency Usage of Blood

- Due to the limited amounts of various groups/types of blood available at this facility, in emergent situations, guidelines will be followed to allow for the available blood to be used to a maximum effect.
- Determine the urgency of the need for blood:
 - 5-10 minutes: Could give group/type specific blood
 - 15-30 minutes: Group/type specific blood and do an immediate spin crossmatch
 - 1 hour: complete a full crossmatch
 - *No matter which option is used, Medical Technologists must complete a full crossmatch to ensure that the patient and units are compatible.*
- If patient's identity is known: We could check to see if a blood group/type has been previously completed and give type specific blood.
- Unknown patient identity: True emergent situation, unable to wait for group/type: Recommendation as follows:
 - Male: Give O Positive units

- Female: If older than 50 years, give O positive units
- If childbearing age, give O negative units until group/type is determined.

UPTOWARD EVENTS IN BLOOD ADMINISTRATION

- The QA/PI Coordinator or designee shall report to the Medical Staff's assigned medical provider reviewer any adverse blood responses. The action will then be the responsibility of the Medical Staff following their review.
- Definition of Adverse Blood Reaction will be:
 - An adverse reaction to transfusion is suspected when there is a sudden and otherwise unexplainable onset of such symptoms such as rash, chills, dyspnea, chest pain, back pain, temperature increase (sustained elevation greater than one degree accompanied by any of the signs/symptoms), hypotension, shock, flushing, hemoglobinuria, oliguria or anuria.
 - Clinical signs onset of symptoms and severity of clinical changes will vary on the type of reaction occurring and the amount of cellular destruction caused by the reaction.
 - Adverse effects of blood transfusion may be classified as either immediate or delayed. Immediate reactions are often apparent within 30 minutes of initiating infusion of the blood products. Delayed reactions may occur as late as 5-11 days after transfusion.
 - Immediate class reactions include:
 - Hemolytic Reactions
 - Anaphylactic Reactions
 - Circulatory Overload

Statistics reviewed will include information provided by laboratory department and/or the Blood Bank package of the laboratory computer system on a quarterly basis:

- Quarterly usage of different blood components
 - Red Blood Cells
 - Fresh Frozen Plasma
 - Platelets
 - Cryoprecipitate
- Overall cross-match/transfusion ratio for:
 - Surgical Patients
 - Obstetrical Patients
 - Medical Patients
- Confirmed transfusion reactions
- Units wasted and reason

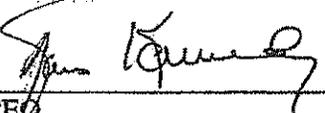
Required Documentation Elements for Blood Products Usage:

- Accepted criteria for use of blood products *must* be reflected in the admission note, progress record, operative note, anesthesia record, lab data or graphic vital sign sheet.
- If indication for use of blood product differs from the accepted criteria, the record *must* reflect the symptoms or rationale for the use of the blood product.
- The record *must* reflect that the transfusion is the preferred form of therapy as opposed to medicinal or surgical therapy (or in addition to those therapies).
- Appropriate laboratory data values prior to administration of the blood product *must* be recorded (exception: blood given during surgery or emergently).
- Subsequent notes or lab data *must* reflect clinical response (i.e. Correction of abnormal parameter toward normal and/or documentation of follow-up HGB or HCT values).
- A statement that no acute complications occurred *must* be in the record.

V. **RESPONSIBILITY:** Laboratory, Nurses, Medical Officer

VI. **AUTHORITY:** The CEO is authorized to enforce this policy

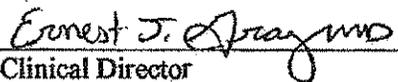
VII. **SUPERCESSION:** This policy supercedes previous Station Policies 01-02-001, 01-08-063.



CEO

11/22/10

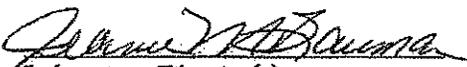
Date



Clinical Director

11/22/2010

Date



Laboratory Director(s)

11/22/10

Date

Distribution: All Departments
Administrative Services, IHS, BAO

Station Policy Manual – Blood Utilization Review
Revised: 11-17-10 LLD

ATTACHMENT A

POLICY FOR BLOOD UTILIZATION REVIEW

TRANSFUSION *NOT MEETING* THE FOLLOWING CRITERIA MUST BE REVIEWED BY A MEDICAL STAFF MEMBER AND/OR THE APPROPRIATE PEER REVIEW COMMITTEE

NOTE: These criteria are extracted from the American Association of Blood Banks (AABB) "Guidelines for Blood Utilization Review" published 2001. The criteria are for auditing blood component administration and must not be misinterpreted as standards of care. These criteria reflect a consensus as to the generally accepted rationale for the use of blood components based published clinical trials, consensus statements, and guidelines produced by national organizations. Review criteria do not necessarily constitute indications, or triggers, for transfusion. Clinical situations may dictate transfusion practices that differ from the review criteria.

<p>I. Red Blood Cells (RBC's). RBC's are transfused to improve oxygen-carrying capacity.</p>	<p>a. Symptomatic anemia in a normovolemic patient, regardless of hemoglobin concentration.</p> <p>b. Evidence of inadequate oxygen delivery or ongoing hemorrhage (e.g. more than {>} 15 percent of blood volume).</p> <p>c. <u>Adults:</u></p> <ul style="list-style-type: none">▪ Hemoglobin less than {<} 8 gram per deciliter {g per dL}. <p>d. <u>Neonates 0 - 28 days old & Newborns 29 days - 1 year old:</u></p> <ul style="list-style-type: none">▪ Hemoglobin <13 g/dL in neonates < 24 hours old, with severe pulmonary disease, cyanotic heart disease, or heart failure (Hct <39)▪ Acute blood loss >10% total blood volume.▪ Phlebotomy losses >5-10% of total blood volume.▪ Hemoglobin level < 8 g/dL in stable newborn infants with clinical manifestations of anemia (Hct < 24). <p>e. <u>Pediatrics over 4 months of age:</u></p> <ul style="list-style-type: none">▪ Intraoperative blood loss > 15% of total blood volume; postoperative
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	<p>hemoglobin level < 8 g/dL, and symptoms or signs of anemia.</p> <ul style="list-style-type: none"> ▪ Acute blood loss with hypovolemia unresponsive to crystalloid or colloid. ▪ Hemoglobin level <13g/dL in patients with severe pulmonary disease requiring assisted ventilation, cyanotic heart disease. ▪ Hemoglobin level <10 g/dL and pre-operative or with symptoms and /or signs of anemia. ▪ Hemoglobin level <8 g/dL with chronic congenital or acquired anemia without an expected satisfactory response to medical therapy. ▪ Chronic transfusions to suppress endogenous hemoglobin production in selected patients with sickle cell or thalassemia syndromes. ▪ Induction of immune tolerance before renal transplantation. <p>f. Preoperative hemoglobin < 9 g per dL and operative procedures or clinical situations associated with major, predictable blood loss.</p> <p>g. Hemoglobin <8 g per dL in a patient on a chronic transfusion regime.</p>
<p>2. Platelets. Platelet transfusion is appropriate to prevent or control bleeding associated with deficiencies in platelet number and function.</p>	<ul style="list-style-type: none"> a. Platelet count <10,000 per microliter (μL) in a non-bleeding patient with failure of platelet production. b. Platelet count <50,000/μL impending surgery or invasive procedure or in a patient experiencing hemorrhage. c. Diffuse microvascular bleeding following cardiopulmonary bypass, or during use of an intra-aortic balloon pump with no significantly abnormal coagulation parameters. d. Diffuse microvascular bleeding in a patient who has lost more than one volume in whom platelet count results

	<p>are not yet available.</p> <p>e. Bleeding in a patient with a qualitative platelet defect, regardless of platelet count.</p> <p>f. <u>Premature infants</u> (gestational age < 37 weeks):</p> <ul style="list-style-type: none"> ▪ Blood platelets <50,000 in a stable infant ▪ Blood platelets <100,000 in a sick infant ▪ {platelets <100,000 + extreme prematurity at high risk for IVH <p>g. <u>All other infants & children:</u></p> <ul style="list-style-type: none"> ▪ Platelet count <5,000- 10,000 in a non-bleeding patient with failure of platelet production. ▪ Platelet count <20,000 in a non-bleeding patient with failure of platelet production and risk factors (sepsis, fever, coagulopathy, etc.). ▪ Platelet count <50,000 with need for an invasive procedure in a child with failure of platelet production. ▪ Blood platelet count <100,000 with active bleeding. ▪ Bleeding in a patient with a qualitative platelet defect, regardless of platelet count. ▪ Diffuse microvascular bleeding following cardiopulmonary bypass, regardless of platelet count.
<p>3. Plasma. Fresh Frozen Plasma (FFP) is administered to correct bleeding due to single or, much more commonly, multiple coagulation factor abnormalities when specific therapy is unavailable.</p>	<p>a. Prothrombin time (PT) or partial prothrombin time (PTT) >1.5 times the mean of the reference range in a non-bleeding patient scheduled for or undergoing surgery or an invasive procedure.</p> <p>b. Diffuse microvascular bleeding in a patient given more than one blood volume and coagulation test results not yet available.</p>

	<p>c. Diffuse microangiopathic hemolytic anemia (e.g., thrombotic thrombocytopenic purpura) being treated with plasma exchange.</p> <p>d. Emergency reversal of coumadin anticoagulation.</p> <p>e. Deficiency of specific factors of the coagulation system when virus-inactivated concentrates are not available.</p>
<p>4. Cryoprecipitated Antihemophilic Factor (AHF). Cryoprecipitated AHF is administered for prevention or treatment of bleeding due to hypofibrinogenia (most commonly), dysfibrinogenemia, Von Willebrand disease (in some circumstances) and (very rarely) Factor VIII Deficiency.</p>	<p>a. Fibrinogen <80 to 100 minigram per deciliter (mg/dL).</p> <p>b. Diffuse microvascular bleeding and fibrogen <100 to 120 mg/dL.</p> <p>c. Von Willebrand disease or hemophilia unresponsive to 1-deamino-8-D-arginine vasopressin (DDAVP) and no appropriate factor concentrate available.</p> <p>d. Uremic bleeding (if DDAVP) is ineffective or after tachyphylaxis).</p> <p>e. Factor XIII deficiency.</p>
<p>5. Special Components. Modified components that provide benefit for selected patient populations.</p>	<p>a. <u>Leukocyte-Reduced Components:</u></p> <ul style="list-style-type: none"> ▪ Prevention of recurrent febrile nonhemolytic transfusion reactions. ▪ Prevention of Human Leukocyte Antigen (HLA) alloantibody formation in select patients. ▪ Prevention of cytomegalovirus (CMV) transmission in selected patients. <p>b. <u>Cytomegalovirus Risk Reduction:</u></p> <ul style="list-style-type: none"> ▪ CMV-seronegative recipients of allogenic progenitor cell transplants. ▪ Intrauterine transfusions. ▪ CMV-seronegative pregnant women. ▪ Low birth weight infants (<1200). ▪ Exchange transfusions in newborns. ▪ Patients with congenital immunodeficiencies. ▪ CMV-seronegative patients with HIV

infection

- CMV-seronegative recipients of a solid organ transplant from a seronegative donor.
- CVM-seronegative patients undergoing chemotherapy that results in a severe neutropenia.
- Pediatric patients

c. Irradiated Blood Components:

- Intrauterine transfusion
- Infants who received intrauterine transfusions.
- Patients with immunodeficiencies.
- Patients undergoing progenitor cell or organ transplantation, either autologous or allogenic.
- Patients receiving HLA-matched cellular components.
- Patients receiving directed units from blood relatives.
- Patients with Hodgkin's disease.
- Pediatric patients

d. Washed Blood Components:

- History of anaphylactic reaction to blood components.
- Immunoglobulin A (IgA) deficiency with documented IgA antibodies.
- Neonatal alloimmune thrombocytopenia or hemolytic disease of the newborn when the mother is the donor for the fetus or newborn infant.

Attachment 7

SUBJECT: PHYSICIAN ORDER REVIEW 24 HR CHART CHECK	PAGE: 1
DEPARTMENT: MEDICAL SURGICAL UNIT	OF: 2
APPROVED BY: NURSING ADMINISTRATION	EFFECTIVE: 9/94
	REVISED: 11/08

PURPOSE:

Provide additional measures of safety in the medication administration process and provide a system that promotes practice consistency and identifies nursing accountability for accurate transcription of patient care orders. Chart checks are to be done on every chart to verify identification is correct on every sheet and to review transcription of medical orders for verification and completeness.

POLICY:

- Every RN and LPN will be responsible to ensure that the physician's orders for each patient has been carried out as ordered. RNs are responsible for verifying orders entered by the medical clerk
- Verification of orders written on the Kardex shall be completed throughout the shift.
- Registered nurse's shall be accountable for accurate transcription of physicians' orders.
- Incomplete orders which are not verified will result in follow-up by the nursing supervisor

PURPOSE:

- To verify the follow-through and transcription of physicians' orders from the previous shift.
- To ensure patient safety and comply with the standards of care.
- To verify the necessity to initiate, continue or change appropriate treatments and preparations as ordered.
- To maintain appropriate continuity in patient care.

PROCEDURE:

- As part of the shift routine, the assigned nurse will inquire about new orders written throughout the shift.
- The nurse will specifically check the physician's order prescribed on the previous shift.

SUBJECT: PHYSICIAN ORDER REVIEW - RESPONSIBILITY OF RN FOR VERIFICATION	PAGE: 2
	OF: 2
DEPARTMENT: MEDICAL SURGICAL UNIT	EFFECTIVE:
APPROVED BY:	REVISED:

- After the assigned nurse verifies that an order has been written, the nurse will promptly obtain the nurse's copy of the order.
- The orders will be reviewed and carried out within one hour of the order being written.
- The Nurse will compare the orders written with the patient's Kardex and the Medication Administration Record.
- A 24 hour chart check will be completed on or around midnight. The nurse will be responsible for verifying that the following have been completed for the 24 hour period.
 - ❖ Review all orders for the last 24 hours for completion and correct transcription.
 - ❖ Check expired narcotics
 - ❖ Check for range orders
 - ❖ Ensure all forms are stamped
 - ❖
- In ink, encompass the orders you have reviewed with a bracket, sign your name, date and time the review.
- If orders have not been carried out, complete an incident report in webcident and notify the nursing supervisor.

Reviewed: 9/49 MW
Reviewed: 6/00 KC
Reviewed: 9/03 KC
Reviewed: 11/07 KC
Revised: 11/08 KC

Attachment 8

**INDIAN HEALTH SERVICE
BLACKFEET COMMUNITY HOSPITAL**

SUBJECT: MEDICATION ADMINISTRATION	PAGE: 1 of 6
DEPARTMENT: MEDICAL SURGICAL UNIT	ORIGINATED: 04/05
APPROVED BY: NURSING ADMINISTRATION	Reviewed/ Revised: 05/12

REFERENCES: (CMS) 482.23

PURPOSE: To ensure safe, appropriate and accurate administration and handling of medication.

POLICY: Medications are administered to patients by qualified personnel in compliance with federal, state laws, and standard of professional practice. Qualified personnel include physicians, registered nurses, licensed practical nurses, respiratory therapist and /or their respective supervised students. Medications are stored, handled and accounted for in a safe manner complying with federal/ state laws and standards of professional practice.

RESPONSIBILITIES:

- A. Licensed prescribers prescribe all medication.
- B. Licensed nurses will:
 - Accept verbal and telephone orders from credentialed licensed prescribers.
 - All orders will be "read back" to the physician for verification.
 - Prepare, administer and document medication administration.
 - Ensure safe handling, storage and security of medications.
 - Provide medication education to patients and to document such education.
 - Report medication errors in webcident and report adverse reactions.

PROCEDURES: All medications require an order which is entered electronically in the patient's health information record and must be dated, timed and signed by the license prescriber. Orders will only be accepted or entered by licensed prescribers, registered nurses, licensed practical nurses, respiratory therapist and pharmacist

All new orders are picked up by pharmacy and verified every 24 hours by night shift licensed nurses to ensure accurate transcription to medication administration records (MAR) per electronic check policy.

SUBJECT: MEDICATION ADMINISTRATION	PAGE: 2 of 6
DEPARTMENT: MEDICAL SURGICAL UNIT	ORIGINATED: 04/05

A kardex exchange occurs daily on day shift between pharmacy and charge nurse or designee to verify MAR and patient pyxis profile.

All patients and/ or family member are questioned about drug allergies and symptoms during admission process. Allergies are noted on MAR, Kardex and admission sheet. Licensed nurses are legally responsible for knowing basic information about the medication they administer such as action, expected effect, interactions, dose limitations and side effects. Medications reference books are available on the Inpatient floor and medication room.

Medications are administered according to the following schedule unless specified differently in the order:

Daily 1000	q 4hr 0200, 0600, 1000, 1400, 1800, 2200
BID 1000, 2200	q 6hr 0400, 1000, 1600, 2200
TID 1000, 1600, 2200	q12hr 1000, 2200
QID 1000, 1400, 1800, 2200	HS 2200
AC ½ hour before meals	PC 1/2 hours after meals

Medications are placed in pyxis under patients profile during normal working hours (Monday Sunday 8:00am to 6:00pm) from the pharmacist. After hours the pyxis is placed on override, therefore, medications can be accessed. The charge nurse can contact the on-call pharmacist for emergency situations.

Emergency Medications are kept in "critical override" in the pyxis and can be accessed at any time. Emergency medications are also kept in a locked drawer on the crash cart. In the event the emergency box is opened, it is to be returned to pharmacy for refills and secured with a lock.

All medications are to be stored and prepared in the designated medication room with limited interruptions. Always wash hands prior to medication administration, check for allergies, check labels for accuracy, read label and compare with MAR. If discrepancies found, verify with physicians orders.

SUBJECT: MEDICATION ADMINISTRATION	PAGE: 3 of 6
DEPARTMENT: MEDICAL SURGICAL UNIT	ORIGINATED: 04/05

Medication may be given ½ hr. before the scheduled time they are due. Narcotics are given, immediately, after taken out of the pyxis.

Implement the “Five Rights” for medication administration.

- Right patient
- Right medication
- Right dose
- Right route
- Right time and frequency
- Positive identification of the patient will be ascertained by the nurse by reading the identification wristband prior to administration of all medication for name and date of birth.

Observe the patient to ensure that the patient swallows all medication following oral administration.

Patients have the right to refuse medication; any medication that is withheld shall be circled and initialed on the MAR. The nurse shall document on the nurse’s narrative notes the reason the drug was not given and, if applicable, the physician is notified.

When preparing the following medications, **two** licensed nurses must check the prepared dosage prior to administration.

- Insulin – The second RN must also verify the order and / or parameters on the MAR
- Heparin and other related anti – coagulants (intravenous or subcutaneous)
- Narcotic PCA pump

Medications are only administered and document by the licensed nurse who has prepared them. After administering a medication to a patient, chart it immediately on the MAR. Mar should be initiated for each entry and when indicated date, time, site, lab value, and dosage documented.

Medication may be self-administered by the patient under licensed nurse personnel supervision only when specifically ordered by the licensed prescriber.

All sterile multiple dose medications vials intended for use by more than one patient are dated and times upon opening and kept no long than thirty (30) days.

All pharmaceuticals dispensed controlled drugs are kept and locked in the pyxis in the medication room. All controlled medications are counted at the end of each shift by two licensed nurses. A report is printed at the pyxis station and turned into each shift respective supervisor. Any discrepancies noted

SUBJECT: MEDICATION ADMINISTRATION	PAGE: 4 of 6
DEPARTMENT: MEDICAL SURGICAL UNIT	ORIGINATED: 04/05

- Will be reported to the charge nurse, supervisor and pharmacy immediately. The nurse supervisor will review the discrepancy and attempt to resolve immediately or take appropriate action.

Medication from home that the patient brings to the hospital will be disposed of in one of two ways:

- Sent home with and immediate relative
- Sent to the hospital pharmacy to be stored until the patient is discharged. Medications are placed in a labeled bad and sent to the Pharmacy. If the patient expires, all personal medication will be destroyed.

A Patient's personal medication can only be used in extreme cases when the medication is not available from the pharmacy and not taking the medication would cause adverse outcome to the patient condition. The admitting physician must write an order for the medication.

No medication will be left at the patient's bedside except for the following: respiratory inhalers, patient-controlled analgesia, antacids, eye drops, throat lozengers and external preps for topical application.

"PRN" medication administered will be qualified by designating the times of administration and parameters, i.e., patient's blood sugar, blood pressure.

Maximum amounts of solution to be administered intramuscularly in one sire include:

- Adults, three (3) ml
- Children, one (1) ml
- Infants, one-half (1/2)

Newborns, one half (1/2)

Subcutaneous injections will be administered in one of the following sites, unless otherwise ordered by the physician.

- The outer aspect of the arm over the triceps;
- The upper portion of the thigh over the quadriceps muscle;
- Any area of the abdomen.

SUBJECT: MEDICATION ADMINISTRATION	PAGE: 5 of 6
DEPARTMENT: Medical Staff, Nursing, Laboratory	ORIGINATED: 04/05

The nurse will review PACU and Anesthesia records of patients returning from Surgery to ascertain doses and times of medications administered in Surgery and the PACU. This also applies to patients transported from the Emergency Department.

All medication orders should contain one specific dosage, never a dosage range, with the exception of those orders using a sliding scale where the parameters are specified by the physician. Orders for medications that are not specific to strength and / or dosage must be cleared with the physician.

The apical pulse will be taken prior to the administration of any digitalis preparation. If the pulse is below 60, the medication will be held and the physician will be consulted. Apical pulse rates, will be recorded in the proper location on the medication sheet.

Orders of medication to be administered via forceful aerosol directly into the respiratory tract, must include:

- Name of medication
- Dosage and /or amount of medication
- Frequency of administration

The Nurse will send copies of Physician's Orders sheets to the pharmacy as soon as possible after a medication or discharge order is written.

Errors in administration of medication will be reported immediately to the attending physician and put into Web cident.

Reviewed 4/05 KC
Revised 11/08 KC

Attachment 9

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Public Health Service
Health Services Administration
Indian Health Service

BLACKFEET SERVICE UNIT STATION POLICY NO. 01-13-053

Patient Visitor Policy

SEC.

1. Purpose
2. Policy
3. Procedures

1. PURPOSE:

To provide for the safety and general well-being of patients, visitors and employees through established visitation practices.

2. POLICY:

The following visiting hours and rules are hereby established as official policy of the Blackfeet Community Hospital (BCH).

Patients, regardless of the nature of their illness, benefit by the presence of close relatives and dear friends. It is the responsibility of the medical and nursing personnel to monitor the visit so that the patient is not fatigued by visits that are too long, too many, or by visits that may upset the patient. The personal comfort of the patients is conducive to recovery and is, therefore, of tantamount importance. Both staff and visitors must remember this and strive to respect patient needs.

While visitors are invited and welcomed, it should be kept in mind that rules for patient visitations are for the good and safety of the patient and not necessarily designed by administration to present barriers for visitors.

3. PROCEDURES:

Patient Visiting Rules:

1. General visiting hours are 11:00 am to 8:00 pm.
2. At 8:00 pm, the end of visiting hours will be announced and the Ward entrance door will be locked.
3. After 8:00 pm visitors will be required to enter thru the E.R. Waiting Area entrance and sign in with security.
4. At the discretion of medical staff, persons with respiratory disease or any sign of infection are not permitted to visit patients.
5. At the discretion of medical staff, during peak times of RSV/FLU, children under 14 years of age will not be allowed on the ward.

6. The dietary department does not provide meals to visitors except as noted below.
7. No alcoholic beverages or illegal substances may be brought to the hospital at any time.
8. This is a tobacco free federal facility, Tobacco products are not allowed.
9. Visitors, relatives, and friends are required to respect the visiting hours and rules, such as *No Tobacco Products, No Admittance, and Employees Only signs*.
10. Food or beverages cannot be brought in for patients unless approved by the patient's doctor.
 - a. Nursing will label food with patient's name and the date.
 - b. Unless consumed immediately, food will be refrigerated.
 - c. Food will be discarded after 24 hours.
11. Visiting patients or others in the hospital under the influence or possession of alcohol or drugs are strictly prohibited.
12. Designated areas shall be closed to the public during working and non-working hours or as dictated by designated officials. Admission to closed areas will be restricted to authorized persons only.
13. Persons on BCH property must comply with official signs of prohibitory, regulatory, or directory nature as well as with the direction of security guards or other authorized staff.
14. Any unwarranted loitering, disorderly conduct, or other conduct on BCH property that creates loud or unusual noise or nuisance, or disrupts performance of official duties, or which prevents the general public from receiving health services, is prohibited.
15. Solicitation of any kind is strictly prohibited.
16. Patient bed's will not be provided to visitor's.
17. Hand washing is required by visitors before entering room or visiting patients and at the end of the visit.

Visiting Hours for Pediatrics

1. An adult is encouraged be present at all times with a patient under the age of 18.
2. A guest food tray will be provided for a parent or guardian who stays with a minor.

Maternity Services

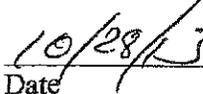
1. A guest food tray will be provided for the family members of a C- section that stays with the patient for the first 24 hours.
2. No children under the age of 12 will be allowed in the Labor and Delivery area with out prior permission from medical staff and patient.

Terminal Patients

1. Visiting hours are unrestricted for relatives of patients who are terminal.

2. A guest food tray will be provided to the family of the terminally ill patient.
3. Coffee will only be provided for the family of terminally ill patients for 8:00 am to 5:00 pm


CEO


Date

Distribution: All Departments

Station Policy Manual

PATIENT INFORMATION

VISITING HOURS AND POLICY

- General visiting hours are 11:00 am to 8:00 pm.
- At 8:00 pm, the end of visiting hours will be announced, ward doors will be locked at that time, no visitors will be allowed in without going through security.
- Hand washing is encouraged at the beginning and end of visitation.
- Persons with respiratory disease or any sign of infection are not permitted to visit patients.
- No children under the age of 14 years of age unless the patient is terminal.
- During peak times of RSV /FLU, children under 14 years of age will not be allowed on the ward.
- No patients will be allowed to "babysit" as an inpatient.
- No guest trays will be provided.
- No alcoholic beverages or illegal substances may be brought to the hospital at any time.
- Sleeping in the bed with a patient will not be tolerated. A chair will be provided if available.
- This is a smoke free, federal facility. Please comply by smoking in designated areas.

VISITING HOURS FOR PEDIATRICS

- Parents will have open visiting hours.
- An adult must be present at all times with a patient under the age of 15.
- No siblings in room.
- A guest tray will be provided for a parent or guardian who stays with the child.

MATERNITY SERVICES

- Spouses and grandparents will have open visiting hours. Visiting hours for siblings will be from 11:00 am to 8:00 pm.
- A guest tray will be provided for the family member of a C-section that stays with the patient for the first 24 hours.
- No children under the age of 12 will be allowed in the Labor and Delivery area without prior permission from the attending provider and/or labor nurse.

TERMINAL PATIENTS

- Visiting hours are unrestricted for relatives of patients who are terminal .
- A guest tray will be provided to the family of the terminally ill patient.
- Coffee is no longer provided for the family of terminally ill patients.

Blood pressures will not be checked when you are a visitor. Over the counter medications such as Tylenol or Motrin can not be given to visitors by the Ward Nursing Staff. Please see your Primary Care provider for any such needs or the providers in the Emergency Department.

CONDITIONS OF ADMISSION

I HEREBY CONSENT (AGREE) TO RECEIVE MEDICAL CARE FROM THE PRACTITIONER(S) RESPONSIBLE FOR MY DIAGNOSIS AND TREATMENT. I understand that I or my authorized representatives have the right to accept or refuse medical care. I may ask questions about my medical care and make my wishes known to my practitioner and or staff. I will participate in my care and foster a safe environment for myself, staff and other patients.

BLACKFEET COMMUNITY HOSPITAL IS NOT RESPONSIBLE FOR MY PERSONAL ITEMS. This includes glasses, dentures, hearing aids or other assistive devices. Personal belongings brought into the facility may be subject to search in an effort to keep staff and visitors safe. Blackfeet Community Hospital shall not be liable for the loss or damage to personal items, including money or articles of value.

THE FOLLOWING ITEMS AND BEHAVIOR ARE NOT PERMITTED ON BCH PROPERTY:

- **WEAPONS:** I agree to turn over all weapons to Security and I understand that if I am suspected of possessing a weapon, BCH has the right to search me and/or my belongings and seize such items.
- **ILLEGAL DRUGS:** Substance abuse is prohibited in all areas of BCH and I agree to turn over any and all illegal substances or contraband. BCH has the right to search me and my belongings and seize such items and I consent to search and seizure.
- **TOBACCO:** BCH is a smoke-free, federal facility. I understand that I may not be allowed to leave the building to smoke or chew tobacco during my treatment. If my practitioner deems it necessary for me to avoid tobacco during my treatment, I understand that help and resources will be available to me to avoid tobacco withdrawal.

I have read the above and understand the content. Changes to this form are not permitted and questions about this form will be addressed by appropriate administrative or clinical staff. If I bring any prohibited items or engage in behavior that is not permitted on federal property, violations may result in additional restrictions and/or discharge.

Patient _____

Patient's Representative _____

Relationship _____

Witness _____

Date _____ Time _____

Unable to obtain signature Reason _____

Attachment 10

DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Public Health Service
Health Services Administration
Indian Health Service

BLACKFEET SERVICE UNIT POLICY NO. 01-13-044

POLICY FOR TOBACCO FREE/NO SMOKING POLICY
SEC.

1. Purpose
2. Policy
3. Procedure
4. Responsibility
5. Authority
6. Supersession

- I. **PURPOSE:** To clarify and establish a uniform policy for Blackfeet Community Hospital within the Billings Area Indian Health Service (BAIHS). The purpose is to implement guidelines that prohibit the use of smoking and other tobacco products in certain locations to ensure that Indian Health Service (IHS) employees, contract employees, students and members of the public, who use or visit IHS, will not be exposed to environmental tobacco smoke. These guidelines will also assist in supporting IHS' mission, which is to raise the health status of American Indians and Alaska Native people to the highest possible level.

The intent is to reduce:

- Risk to patients who use tobacco products, including possible adverse effects on treatment;
- Risks of passive smoking for others;
- The risk of fire.¹

- II. **POLICY:** In accordance with Executive Order 13058 and the IHS Circular #2006-03, the use of tobacco in any form including smoking material is prohibited in all occupied interior space owned, rented, or leased, by the Executive Branch of the Federal Government and in front of air intake ducts in any outdoor areas (excludes government housing).^{2,3} All patients, visitors, employees and students will be appropriately informed of the Tobacco Free/No Smoking Policy. All employees are expected to set the example and to comply with all requirements.

¹ CMS 481.41(b)

² Executive Order 13058

³ IHS Circular #2006-03

III. PROCEDURES:

IV.

A. The use of tobacco products shall not be permitted in the following locations:

- Inside any occupied building that is owned, leased, or rented by the IHS.
- Within 25 feet of the perimeter of any IHS building.
- In front of any IHS' building air intake ducts
- Within 25 feet of IHS building entrances and exits.⁴

B. All patients, visitors, and employees are informed about the Tobacco Free/ No Smoking Policy.

- Visitors will be informed by signs and/or by the appropriate hospital personnel.
- All patients will be informed by nursing personnel upon admission to the hospital during the admission process.
- All employees and students will be informed through the orientation process and during annual safety updates.

C. Designated Smoking Areas have been established to provide areas for those individuals who smoke. The designated areas are:

- 25 feet away from all of the outside entrances: Ward, Main Lobby, Emergency Room and all other entrances/exits around the facility.
- 25 feet away from the Ambulance garage doors/entrance by the Emergency Room.

D. In support of IHS' mission, we encourage and support anyone who desires assistance in eliminating his or her dependence on the use of tobacco products through smoking cessation programs.

- Patients are routinely asked about tobacco use during outpatient visits. When the patient uses tobacco, they are offered cessation services.
- Inpatients are asked about tobacco use during the admission process. When the patient uses tobacco, they are offered cessation services.

IV. RESPONSIBILITY:

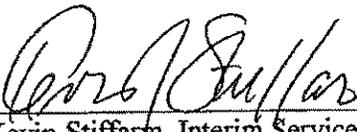
- It is the responsibility of all personnel to ensure compliance with the Tobacco Free/No Smoking Policy. When individuals are found smoking within the facility or in no smoking areas, personnel will politely request that they extinguish their smoking material and/or advise them to please move to an acceptable location.
- It is the responsibility of employees, contract employees, volunteers and students who use tobacco and work within IHS facilities to comply with this policy. There is an expectation that these individuals will set an example for patients and visitors to follow when smoking that supports the mission of Indian Health Service and respects the rights of others to be free from exposure to environmental smoke.

⁴ Executive Order 13058

V. AUTHORITY:

- The Blackfeet Service Unit Director grants authority to the Safety Committee to oversee this policy.
- Supervisors have the authority to deal with employees who violate this policy.

VII. SUPERCESSION: This policy supersedes previous Station Policy #01-05-041



Kevin Stiffarm, Interim Service Unit Director

5/8/13

Date

Distribution: All Departments
Administrative Services, IHS, BAO

Station Policy Manual

View Header

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release August 9, 1997

EXECUTIVE ORDER 13058

PROTECTING FEDERAL EMPLOYEES AND THE PUBLIC FROM EXPOSURE TO TOBACCO SMOKE IN THE FEDERAL WORKPLACE

By the authority vested in me as President by the Constitution and the laws of the United States of America and in order to protect Federal Government employees and members of the public from exposure to tobacco smoke in the Federal workplace, it is hereby ordered as follows:

Section 1. Policy. It is the policy of the executive branch to establish a smoke-free environment for Federal employees and members of the public visiting or using Federal facilities. The smoking of tobacco products is thus prohibited in all interior space owned, rented, or leased by the executive branch of the Federal Government, and in any outdoor areas under executive branch control in front of air intake ducts.

Sec. 2. Exceptions. The general policy established by this order is subject to the following exceptions:

- (a) The order does not apply in designated smoking areas that are enclosed and exhausted directly to the outside and away from air intake ducts, and are maintained under negative pressure (with respect to surrounding spaces) sufficient to contain tobacco smoke within the designated area. Agency officials shall not require workers to enter such areas during business hours while smoking is ongoing.
- (b) The order does not extend to any residential accommodation for persons voluntarily or involuntarily residing, on a temporary or long-term basis, in a building owned, leased, or rented by the Federal Government.
- (c) The order does not extend to those portions of federally owned buildings leased, rented, or otherwise provided in their entirety to nonfederal parties.
- (d) The order does not extend to places of employment in the private sector or in other nonfederal governmental units that serve as the permanent or intermittent duty station of one or more Federal employees.
- (e) The head of any agency may establish limited and narrow exceptions that are necessary to accomplish agency missions. Such exception shall be in writing, approved by the agency head, and to the fullest extent possible provide protection of nonsmokers from exposure to environmental tobacco smoke. Authority to establish such exceptions may not be delegated.

Sec. 3. Other Locations. The heads of agencies shall evaluate the need to restrict smoking at doorways and in courtyards under executive branch control in order to protect workers and visitors from environmental tobacco smoke, and may restrict smoking in these areas in light of this evaluation.

Sec. 4. Smoking Cessation Programs. The heads of agencies are encouraged to use existing authority to establish programs designed to help employees stop smoking.

Sec. 5. Responsibility for Implementation. The heads of agencies are responsible for implementing and ensuring compliance with the provisions of this order. "Agency" as used in this order means an Executive agency, as defined in 5 U.S.C. 105, and includes any employing unit or authority of the Federal Government, other than those of the legislative and judicial branches. Independent agencies are encouraged to comply with the provisions of this order.

Sec. 6. Phase-In of Implementation. Implementation of the policy set forth in this order shall be achieved no later than 1 year after the date of this order. This 1 year phase-in period is designed to establish a fixed but reasonable time for implementing this policy. Agency heads are directed during this period to inform all employees and visitors to executive branch facilities about the requirements of this order, inform their employees of the health risks of exposure to environmental tobacco smoke, and undertake related activities as necessary.

Sec. 7. Consistency with Other Laws. The provisions of this order shall be implemented consistent with applicable law, including the Federal Service Labor-Management Relations Act (5 U.S.C. 7101 et seq.) and the National Labor Relations Act (29 U.S.C. 151 et seq.) Provisions of existing collective bargaining agreements shall be honored and agencies shall consult with employee labor representatives about the implementation of this order. Nothing herein shall be construed to impair or alter the powers and duties of Federal agencies established under law. Nothing herein shall be construed to replace any agency policy currently in effect, if such policy is legally established, in writing, and consistent with the terms of this order. Agencies shall review their current policy to confirm that agency policy comports with this order, and policy found not in compliance shall be revised to comply with the terms of this order.

Sec. 8. Cause of Action. This order does not create any right to administrative or judicial review, or any other right or benefit, substantive or procedural, enforceable by a party against the United States, its agencies or instrumentalities, its officers or employees, or any other person or affect in any way the liability of the executive branch under the Federal Tort Claims Act.

Sec. 9. Construction. Nothing in this order shall limit an agency head from establishing more protective policies on smoking in the Federal workplace for employees and members of the public visiting or using Federal facilities.

WILLIAM J. CLINTON

THE WHITE HOUSE,
August 9, 1997.

###

Special General Memorandums (SGMs)

General Administration Manual (GAM)

Delegations of Authority:

- Commissioned Corps Program
- Personnel
- Administrative

Transmittal Notices

Organizational Charts

Functional Statements

Questions or Comments. Please contact the Content Manager.

ROCKVILLE, MARYLAND 20852

Refer to: OCPS/DCCS

INDIAN HEALTH SERVICE CIRCULAR NO. 2006-03

Effective Date: 04/28/2006

TOBACCO-FREE POLICY

Sec.

1. Purpose/Background
2. Definitions
3. Policy
4. Scope
5. Exceptions
6. Authority
7. Implementation
8. Responsibilities
9. Enforcement
10. Supersedure
11. Effective Date

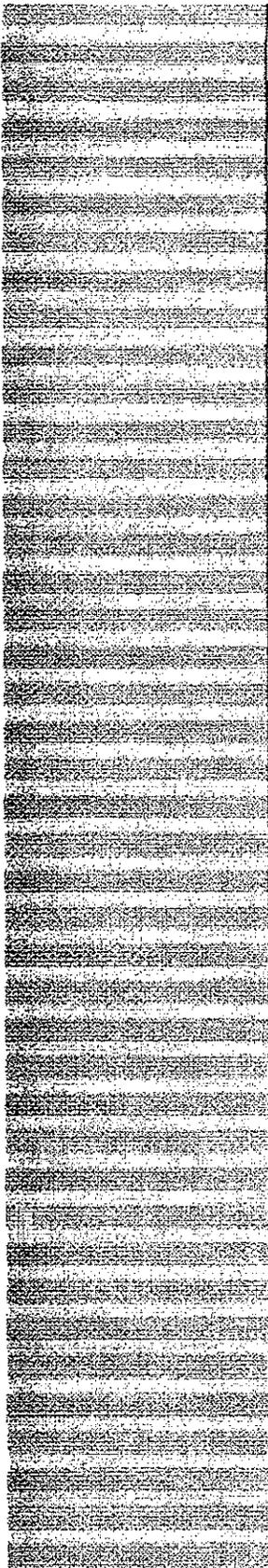
1. **PURPOSE.** This circular establishes the Indian Health Service (IHS) policy prohibiting the use of commercial tobacco in IHS-operated properties to protect the health, safety, and comfort of IHS employees, contractors, and visitors. It is recognized that this policy will require behavior modification on the part of individuals who use tobacco products. It is the intent of this policy to support employees' efforts to cease using tobacco products through the "Tobacco Cessation Program" or any effective similar program.

2. **BACKGROUND.** Research indicates that smoking is the major preventable cause of illness and premature death in the United States. Over 400,000 people die annually as a result of tobacco use. Moreover, exposure to second-hand smoke is linked to a variety of negative health consequences and is responsible for approximately 3,000 lung cancer deaths annually among nonsmokers in the United States.

In 1997, Executive Order 13058, "Protecting Federal Employees and the Public from Exposure to Tobacco Smoke in the Federal Workplace," issued by the President of the United States, established a smoke-free environment for Federal employees and members of the public visiting or using Federal facilities. The smoking of tobacco products is prohibited in all interior space owned, rented, or leased by the Executive Branch of the Federal Government and in front of air intake ducts in any outdoor areas under Executive Branch control.

3. **DEFINITIONS.**

- A. **Property Owned or Leased by the IHS.** All properties, whether owned or leased, directly operated by IHS.
- B. **Tobacco.** The term "tobacco" includes cigarettes, cigars, pipes, chewing tobacco, and smokeless tobacco products.
- C. **Second-Hand Smoke.** Second-hand smoke is environmental tobacco smoke that is inhaled involuntarily or passively by someone who is not smoking.

- 
4. **POLICY.** The use of tobacco is prohibited on all IHS-operated properties, unless such use is allowed under terms of the current lease. In all such cases, the lease terms will be renegotiated at the earliest opportunity to reflect a zero tolerance for the use of tobacco products. This includes IHS Headquarters, Area Offices, hospitals, health clinics/stations, and all other offices or facilities. All areas that were previously designated for outdoor smoking are hereby eliminated. The use of tobacco is prohibited, in any form, at IHS-operated properties including
- A. All interior and exterior spaces of IHS-operated properties.
 - B. All IHS-operated spaces in multi-tenant buildings.
 - C. All Government vehicles regardless of their location.
5. **SCOPE.** This policy applies to all IHS employees, clients, contractors, and visitors.
6. **EXCEPTIONS.**
- A. **Traditional Beliefs and Ceremonial Practices.** The IHS continues to recognize the value and efficacy of patients' traditional beliefs and ceremonial practices. The use of tobacco for ceremonial purposes is allowed in the designated traditional healing room, including any space designated for a ceremony, or in a patient's private hospital room.
 - B. **Space Not Operated by the IHS.** Any spaces outside the leased areas of multi-tenant facilities not solely operated by the IHS.
 - C. **Residential Property.** Any IHS residential property such as Government housing quarters.
7. **AUTHORITIES.**
- A. Department of Health and Human Services (HHS) "Tobacco-Free HHS Policy," dated January 3, 2005 (Supplemented on January 14, 2005)
 - B. Department of Health and Human Services, General Administration Manual, HHS Transmittal 87.01, Attachment IV, "Policy on Smoking in HHS Occupied Buildings and Facilities"
 - C. Executive Order 13058, "Protecting Federal Employees and the Public from Exposure to Tobacco Smoke in the Federal Workplace," effective date August 9, 1997
 - D. Public Health Service Act, Section 1701(a)(7)(A)
 - E. Comprehensive Smoking Education Act of 1984
 - F. Comprehensive Smokeless Tobacco Health Education Act of 1986, (the "Smokeless Tobacco Act"), codified at 15 United States Code (U.S.C.) 1341 and 4401-08
8. **IMPLEMENTATION.** The implementation of the Tobacco-Free Policy is a component of

a larger initiative to improve the health and wellness of our employees, patients, and visitors. The implementation of this policy will be accompanied by an emphasis on education and awareness programs, such as:

- A. **Smoking Cessation Programs.** The IHS will continue to offer support to employees who wish to stop using tobacco products through the Employee Assistance Program and the Tobacco Cessation Program offered by the Federal Occupational Health (FOH) Tobacco cessation classes are offered through the FOH for Federal employees who would like to take this opportunity to quit using tobacco. The FOH can be reached at (206) 615-2546, or employees can access the HHS Web site at <http://www.surgeongeneral.gov/tobacco/default.htm> for information regarding tobacco cessation programs.
- B. **Other Tobacco Cessation Resources and Important Links.**
 - 1. Free Quitline Smoking Cessation (1) 877-724-1090 The line is answered by a group of clinical counselors
 - 2. American Cancer Society <http://www.cancer.org>
 - 3. American Lung Association <http://www.lungusa.org>
 - 4. American Heart Association <http://www.americanheart.org>
- C. **Health and Wellness.** The IHS will promote activities that highlight the importance of health and wellness in general.
- D. **Posters and Flyers.** Educational posters and flyers will be strategically placed throughout the facilities.

9. RESPONSIBILITIES.

- A. **Director, IHS.** The Director, IHS, or his/her designee is responsible for implementing and ensuring compliance with the Tobacco-Free Policy across the entire IHS. The Director, IHS, or his/her designee shall ensure that Headquarters Office Directors, Area Directors, and service unit Chief Executive Officers (CEO) are responsible for the implementation of and compliance with the "Tobacco-Free Policy" in their respective programs and administrative areas.
- B. **Director, Division of Grants Operations.** The Director, Division of Grants Operations, is responsible for encouraging all recipients of an IHS grant to provide their employees a tobacco-free workplace and promote the non-use of all tobacco products.
- C. **Director, Division of Administrative Services.** The Director, Division of Administrative Services, is responsible for instructing all security personnel:
 - 1. to advise Headquarters employees and visitors of the IHS Tobacco-Free Policy,
 - 2. to document all non-compliance incidents in an incident log, and
 - 3. to forward a biannual report on all incidents of noncompliance to the designated Headquarters Tobacco-Free Coordinator. The reports will be

submitted for 2 years, at the end of which the implementation progress will be reevaluated to see if further reporting is warranted.

- D. Director, Division of Human Resources.** The Director, Division of Human Resources, includes a copy of this circular in all new employee and student orientation programs.
- E. Human Resource Staff.** All levels of Human Resource staff are responsible for reporting the number of written warnings and forwarding the compiled report to the designated Tobacco-Free Coordinator at all levels every 6 months for 2 years.
- F. Headquarters Tobacco-Free Coordinator.** The Headquarters Tobacco-Free Coordinator will:
1. ensure that suitable uniform signs for Headquarters stating, "~~Do Not Use Tobacco in Facility or on Grounds~~" are posted at the entrance to the property and near entrance doors of buildings for the public to view. The signs should be posted no later than 60 days after implementation of this policy.
 2. compile Area and Headquarters reports and send them to the HHS Tobacco-Free Coordinator every 6 months. The compiled reports will be submitted for 2 years, at the end of which the implementation progress will be reevaluated to see if additional reporting is required.
 3. prepare a report of all incidents documented in the Headquarters incident log as reported by security personnel.
 4. ensure that all levels of staff are informed of the Tobacco-Free Policy
 5. ensure that managers and supervisors at all levels are responsible for the enforcement of this policy.
 6. increase employee awareness of this Tobacco-Free Policy via written and electronic notices.
- G. Area Director.** The Area Director or his/her designee is responsible for the distribution of the Tobacco-Free Policy to the service unit CEOs and Health Clinic Directors to ensure that their facilities are in compliance with the Tobacco-Free Policy. The Area Director or his/her designee shall:
1. designate an Area Tobacco-Free Coordinator to receive, compile, and summarize reports consisting of policy implementation, barriers, and recommendations to assess the progress of implementation from the service units. The compiled report will be forwarded to the Headquarters Tobacco-Free Coordinator every 6 months for 2 years.
 2. ensure that Area and service unit managers, supervisors, and employees are informed of and are in compliance with the Tobacco-Free Policy.
 3. ensure the appropriate manuals are updated to include this Tobacco-Free Policy.
 4. encourage Tribal Leaders to adopt and implement a similar tobacco-free

circular.

- H. **Contracting Officers.** Contracting Officers shall ensure that all contractors are notified of the Tobacco-Free Policy.
- I. **Regional Human Resources Officers.** The Regional Human Resources Officers shall include a copy of this circular in all new employee and student orientation programs.
- J. **Chief Executive Officer.** The CEO or his/her designee is given the responsibility of informing the staff of the Tobacco-Free Policy through memoranda, staff meetings, newsletters, e-mail broadcasts, bulletin announcements, and/or department meetings. The CEO or his/her designee shall:
1. notify the local Tribal Health Board about the IHS Tobacco-Free Policy.
 2. notify the public about the IHS Tobacco-Free Policy through public meetings, radio, posted announcements, newsletters, community bulletins, Web site announcements, and/or local newspapers in accordance with IHS Public Affairs policies.
 3. ensure that employees are informed and in compliance with the Tobacco-Free Policy.
 4. instruct the security supervisor to ensure that incidents of non-compliance are documented (including visitors, patients, and employees).
- K. **Security personnel.** Security personnel are responsible for:
1. documenting in a log verbal warnings and the number of visitors asked to leave after refusing to comply with the policy and forwarding the compiled report to their designated Tobacco-Free Coordinator once every 6 months for 2 years.
 2. identifying employees who are not in compliance with the policy and reporting them to the appropriate manager or supervisor.
- L. **Tobacco-Free Coordinator.** Tobacco-Free Coordinators will assess the progress of implementation by summarizing reports on policy implementation, barriers to implementation, and recommendations to improve compliance progress reports. The reports will be forwarded to the designated Area Tobacco-Free Coordinator every 6 months for 2 years.
- M. **Facility Management Supervisor.** The Facility Management Supervisor is to remove all "No Smoking" signs and replace them with new signs stating that ~~no tobacco products may be used in this tobacco-free environment.~~ The signs should be posted at the entrance to the property and near the entrance doors of the building for the public to view. The signs should be posted in each location no later than 60 days after implementation of the policy.
10. **ENFORCEMENT.** Managers and supervisors at all levels are responsible for the enforcement of this policy and for documenting verbal warnings.



- A. **Employee Violation.** Employees who fail to comply with this policy may be subjected to appropriate disciplinary action.
- B. **Visitors and Patient Violations.** Visitor and patient violations shall be handled accordingly:
 1. The visitor or patient is to be informed politely of the IHS Tobacco-Free Policy.
 2. Security personnel shall ask patients or visitors who refuse to comply with the policy to leave the property and shall document the incident.
- 11. **SUPERSEDURE.** This circular supersedes the IHS Special General Memorandum No. 2002-04 "Protecting IHS Employees and the Public from Exposure to Tobacco Smoke in the Federal Workplace and in United States Government Vehicles," dated August 26, 2002.
- 12. **EFFECTIVE DATE.** This circular is effective on the date of signature by the Director, IHS. There will be a grace period of 3 months to allow individuals to adjust to the changes required by this policy.

/Charles W. Grim, D.D.S./
 Charles W. Grim, D.D.S., M.H.S.A.
 Assistant Surgeon General
 Director, IHS

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Indian Health Service (HQ) - The Reyes Building, 801 Thompson Avenue, Ste. 400 - Rockville, MD 20852

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Attachment 11



June 28, 2013

Memo

To: All Nursing Staff
Blackfeet Community Hospital / IHS
Blackfeet Service Unit

From: Susan K. Head, RN, BSN *AKH*
Director of Nursing

Re: Re issue of Memo 2/19/2012

It has been brought to my attention of staff sleeping during their tour in the staff lounge and patient room.

Effective today, all nursing staff is reminded of their accountability and responsibility of their nursing duty to the safety and quality care of all patients at the Blackfeet Community Hospital therefore sleeping during your tour of duty at the facility is unacceptable.

The Charge Nurse of each shift is responsible for staff assignments including assignment for official breaks to ensure appropriate staff is available at all times.

Any further complaints will be addressed at the next level if this type of behavior is continues.

For questions please contact the Director of Nursing at extension 6269. Thank you