Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Allegations Concerning Respiratory Therapy and Nursing VA Medical Center Memphis, Tennessee

Report No. 09-03815-170

June 10, 2010

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections, conducted an evaluation in response to two anonymous complaints regarding respiratory therapy (RT) and nurse staffing issues at the VA Medical Center (the medical center) in Memphis, Tennessee. The purpose of the review was to determine whether the allegations had merit.

We confirmed that two RTs and a surgery resident were unable to intubate a patient; however, we did not substantiate that this contributed to the patient's death. Medical record documentation clearly reflects that the patient was ventilated between intubation attempts, and RT competency files reflected appropriate certification and competence in airway management. We did not substantiate that ambulatory surgery unit nurses were assigned to the gastroenterology (GI) recovery unit, leaving the ambulatory surgery unit unsafely staffed. We also did not substantiate that an ambulatory surgery unit nurse worked alone on the GI recovery unit. The units were physically located in the same space and nurses could easily assist each other if needed. We noted that actions were being taken to enhance RT and nurse staffing in both areas.

The VISN and medical center Directors agreed with our report. We made no recommendations.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

TO: Director, VA Mid-South Healthcare Network (10N9)

SUBJECT: Healthcare Inspection – Allegations Concerning Respiratory Therapy and Nursing, VA Medical Center, Memphis, Tennessee

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI), conducted an evaluation in response to two anonymous complaints regarding respiratory therapy (RT) and nurse staffing issues at the VA Medical Center (the medical center) in Memphis, Tennessee. The purpose of the review was to determine whether the allegations had merit.

Background

The medical center provides inpatient and outpatient medical, surgical, mental health, and geriatric specialty services. It operates 244 hospital beds, including 10 medical intensive care unit (MICU) beds. It is part of Veterans Integrated Service Network (VISN) 9.

On September 30, 2009, the OIG hotline received a complaint alleging that:

- "Incompetent" RTs working on the night shift were unable to intubate[1] a patient, resulting in his death.
- The patient's death was indicative of long-standing RT staffing problems that had not been addressed by management.

On October 1, the OIG hotline received a complaint alleging that:

- Ambulatory surgery nurses were reassigned to the gastroenterology (GI) recovery unit, leaving the ambulatory surgery unit unsafely staffed.
- An ambulatory surgery unit nurse worked alone in the GI recovery unit on several occasions.

In addition, both complainants made allegations related to inappropriate management practices; those administrative allegations were not evaluated in this report.

[1]Insertion of a tube into the trachea to establish and/or maintain an airway.

Scope and Methodology

We conducted a site visit on November 18–19, 2009. Prior to our visit, we reviewed local and Veterans Health Administration (VHA) policies,[2] American Society of PeriAnesthesia Nurses (ASPAN) staffing and personnel management standards, and the patient's medical record. While onsite, we reviewed RT intubation records and staffing reports for September 2008–September 2009; RT training and competency files; the patient's death certificate; patient incident reports and certified nursing time schedules for April 2009–September 2009; and vacancy and recruitment status reports for the ambulatory surgery and GI recovery units. We interviewed clinical and administrative staff with knowledge of the emergency airway management and nurse-staffing processes.

We conducted the review in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Issue 1: RT Competency and Staffing

Case Summary

The patient was an obese male in his seventies with a past medical history of diabetes mellitus, hypertension, chronic obstructive pulmonary disease, atrial fibrillation,[3] and prostate cancer, who presented to the emergency room early August 2009, with sudden-onset abdominal pain. He was diagnosed with rectus abdominus hematoma[4] and admitted to the MICU. The patient was stabilized and transferred to the medical floor. The patient complained daily of abdominal pain and was treated with pain medications. A physician documented that the rectus abdominus hematoma appeared to have enlarged and was more rigid than the previous day. A CT scan was ordered but did not confirm enlargement of the hematoma. RT staff notified the assigned nurse and physician that the patient was in respiratory distress due to his enlarged abdomen. The patient developed respiratory failure, was intubated without difficulty by RT staff, and transferred to the MICU.

The patient was transferred back to the medical floor two weeks later but subsequently developed kidney failure and fluid retention, which impaired his ability to breathe. The patient was treated with dobutamine, a medication that increases the amount of blood the heart pumps, thus increasing blood flow through the kidneys. Nephrologists[5] did not think the patient was a dialysis candidate secondary to his compromised medical

[2]Directive 2005-031, *Out-of-Operating Room Airway Management*, dated August 8, 2005.
[3]A type of abnormal heart rhythm.
[4]Localized swelling caused by blood in the muscles at the front of the abdomen.
[5]Internal Medicine specialist physicians who diagnose and treat kidney diseases.

condition and poor likelihood of recovery from this complex course of illness. In late August, he was transferred back to the MICU when he again experienced difficulty breathing. He was provided respiratory support but did not require intubation. Over the course of the week, the patient developed multi-organ failure. Providers informed the patient's family that he was not responding to treatment and had a poor prognosis. The family requested to continue all treatments despite the patient's rapidly declining clinical status.

In early September, the patient suffered a cardiac arrest. Staff initiated advanced cardiac life support. Two RTs and one surgery resident attempted intubation several times but were all unsuccessful. The patient was pronounced dead at 4:25 a.m.

RT Competency. We did not substantiate that the patient died due to incompetent RTs working on the night shift. While documentation reflects that the RTs and a surgical resident could not intubate the patient, we could not establish that this contributed to the patient's death. Medical record documentation clearly reflects the patient was adequately ventilated[6] by bag-valve-mask[7] between intubation attempts. Physicians consistently documented the patient's complex health problems and declining condition. The death certificate listed the cause of death as multi-system organ and congestive heart failure, which was consistent with the patient's diagnoses and clinical course. The family declined an autopsy.

We also found current airway management certifications and competencies for the two RTs who attempted to intubate the patient.

RT Staffing. While we did not substantiate that the patient's death was indicative of long-standing RT staffing problems, the RT Director confirmed that recruitment was a challenge during the period covered by the allegations. Staffing guidelines require a minimum of five RTs be scheduled to work the night shift. We found that only three RTs worked the night in question; therefore, staffing did not meet local guidelines. Since our site visit, managers have increased RT staffing by converting one part-time fee-basis RT to full-time, hiring two new RTs (pending Human Resources clearance), and initiating recruitment for three working RT supervisor positions.

Issue 2: Nurse Staffing

We did not substantiate that ambulatory surgery unit nurses were assigned to the GI recovery unit, leaving the ambulatory surgery area unsafely staffed. Five registered nurses were allocated to the ambulatory surgery unit. At the time of our visit, four nurses were working full-time and a fifth nurse had been selected but had not yet reported to

[6]The exchange of air between the lungs and the environment, including inhalation and exhalation.
[7]Allows for oxygenation and ventilation of patients until a more definitive airway can be established and in cases where endotracheal intubation or other definitive control of the airway is not possible.

duty. The GI unit was fully staffed with eight nurses. The ambulatory surgery and GI recovery units are co-located, permitting nurses to assist each other if needed. All nurses assigned to the shared unit maintain competencies for both areas, and nurse assignments are based on patient care needs for that day. Our review of quality and risk management reports for the period April 2009 to September 2009 did not reveal any patient incidents or adverse outcomes related to nurse staffing in the ambulatory surgery or GI recovery units.

We did not substantiate that an ambulatory surgery unit nurse worked alone in the GI recovery unit on any of the dates provided by the complainant. Because nurses are assigned based on patient care needs, we cannot say with certainty how many nurses should have been assigned to GI recovery at a particular time on a particular day. The number would fluctuate depending on patient volume and acuity. ASPAN guidance allows cross-coverage in the ambulatory surgery/GI recovery units because of the physical layout of the space. We found that on the dates in question, nursing staff were assigned to and available on the ambulatory surgery/GI unit. It was unclear whether the GI nurse who was allegedly working alone requested assistance.

While nurse staffing appeared to be adequate to cover the ambulatory surgery and GI areas, we were told that registered nurses also performed clerical duties that decreased the amount of time they could spend meeting patient care needs. In May 2009, nursing staff met with the Associate Chief Nurse for Surgery to discuss staffing concerns. As a result of the meeting, managers decided to hire a health technician (HT) to assist with non-nursing duties and patient care needs. At the time of our visit, hiring for the HT position was in progress.

Conclusions

We confirmed that two RTs and a surgery resident were unable to intubate a patient; however, we did not substantiate that this contributed to the patient's death. Medical record documentation clearly reflects that the patient was ventilated between intubation attempts, and RT competency files reflected appropriate certification and competence in airway management. The death certificate lists the cause of death as multi-organ and congestive heart failure, consistent with the patient's diagnoses and complex clinical course.

We did not substantiate that ambulatory surgery unit nurses were assigned to the GI recovery unit, leaving the ambulatory surgery unit unsafely staffed. We also did not substantiate that an ambulatory surgery unit nurse worked alone on the GI recovery unit. The units were physically located in the same space and nurses could easily assist each other if needed. We found no evidence of patient incidents or adverse events on the ambulatory surgery or GI recovery units during the time in question. Also, we noted that

actions were being taken to enhance RT and nurse staffing in both areas. The VISN and medical center Directors agreed with our report. We made no recommendations.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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Appendix A

OIG Contact and Staff Acknowledgments

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Acknowledgments	Jerome Herbers, MD Susan Zarter, RN

Appendix B

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