Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care Issues
Edward Hines, Jr. VA Hospital
Hines, Illinois

Report No. 11-01485-117 **March 8, 2012**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection at the Edward Hines Jr. VA Hospital, Hines, Illinois, at the request of the Chicago OIG Office of Criminal Investigations Division (CID). The purpose of the investigation was to determine if substandard quality of care contributed to the self-extubation and subsequent death of a veteran.

Our inspection found that facility staff (the intensive care managers, respiratory care services manager, risk managers, and performance improvement managers) reviewed the incident and developed performance improvement procedures. The medical and surgical intensive care units, and the Respiratory Care Services Department managers have implemented policies and procedures that establish responsibility and accountability for verifying and documenting all alarms related to patient safety and monitoring are functional. Additionally, following the incident, the Respiratory Care Services Department managers have implemented policies and procedures to verify and document the security of the endotracheal tube, to include cuff pressure, on all patients receiving ventilator-assisted mechanical respirations.

The Biomedical Engineering Department installed devices (metal cages) to prevent tampering, silencing, and disabling the telemetry alarms at the central nurses' station in the medical and surgical intensive care units. However, the design of the cages does not prevent disabling of the alarms.

We recommended that the facility report the incident to the VA National Center for Patient Safety to decrease the potential for poor patient outcomes, that Biomedical Engineering Department reduce the width and length of the access opening on the metal cages surrounding the audio system to ensure that staff do not inadvertently render the system inaudible, and that managers ensure all nursing personnel are knowledgeable of the new policies and procedures.

The VISN and Facility Directors agreed with the findings and recommendations. The implementations plans are acceptable, and we will follow up on the planned actions until they are completed.

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

TO: Veterans Integrated Service Network Director 12

SUBJECT: Healthcare Review – Quality of Care Issues, Edward Hines, Jr. VA Hospital, Hines, Illinois

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection at the Edward Hines Jr. VA Hospital, Hines, Illinois, at the request of the Chicago OIG Office of Criminal Investigations Division (CID). The purpose of the investigation was to determine if substandard quality of care contributed to the self-extubation and subsequent death of a veteran.

Scope and Methodology

We reviewed the VA OIG CID's report, the patient's medical record, and pertinent policies and procedures associated with quality of care of Medical Intensive Care Unit (MICU) patients. We reviewed the standard operating procedures for the MICU and the clinical competencies required for the positions of MICU Charge Nurse, registered nurse, and respiratory therapists. We reviewed the findings of the facility's nursing peer review and investigations. On November 1 and 8, 2011, we conducted onsite interviews with key staff.

We inspected the MICU and Surgical Intensive Care Unit (SICU) and we tested the functionality of the telemetry alarms at the central nurses' stations.

Case Review

In late September 2010, the patient, a man in his sixties with a history of Amyotrophic Lateral Sclerosis[1] (ALS) with bulbar symptoms, was admitted to the MICU, Edward Hines Jr. VA Hospital after presenting to the emergency department with a complaint of shortness of breath. The patient also had a history of obesity, hyperlipidemia, hypercapneic/hypoxic respiratory failure and recurrent aspiration pneumonia. The

[1] Amyotrophic Lateral Sclerosis is a degenerative disease that affects nerve cells in the brain and the spinal cord causing progressive lost of the ability of the brain to initiate and control muscle movement.

admitting diagnoses were respiratory failure and aspiration pneumonia. The plan of care included treatment with intravenous (IV) antibiotics, BiPAP[2] therapy, and possible placement of tracheostomy and percutaneous endoscopic gastrostomy tube[3]. On the fourth hospitalization day, the patient failed BiPAP therapy and required mechanical ventilation via an endotracheal tube.

On the fifth hospitalization day, the patient became extubated and advanced life-saving procedures (Code Blue) were initiated. The advanced life-saving procedures resulted in the patient being reintubated and the use of continuous IV medications to maintain a blood pressure consistent with life.

It was considered that the patient may have been intentionally extubated because the patient was sedated and his hands were physically restrained.

In late September 2010, the patient had several electroencephalograms and was evaluated by the neurology team. It was concluded that the patient had sustained an anoxic brain injury prior to or during the Code Blue procedures and that his prognosis was very poor. The patient's wife and siblings were informed of the prognosis and they decided to discontinue artificial respirations. In early October 2010, the patient was removed from the ventilator, comfort care was provided, and the patient expired approximately 4 hours later.

The VA OIG CID investigation did not uncover any evidence of foul play. Their investigation did reveal quality of care concerns that may have contributed to the MICU staff's response to the patient's extubation and to the overall care of veterans in the MICU. Specifically, it was reported that nurses silence alarms at the central nurses' station. The alarms are used to alert MICU staff that patients are experiencing a life-threatening event. The VA OIG CID interviewed five nurses and one physician who reported being unsure if the alarms at the central nurses' station sounded when the veteran became extubated. Additionally, in mid February 2011, during a tour with Biomedical Engineering Department staff, VA OIG CID found the alarms (similar to computer speakers) at the central nurses' station in the MICU and SICU had been rendered inaudible and/or manually disabled.

We conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[2] BiPAP is a device used to administering positive air pressure into the lungs. BiPAP treatments are used to treat patients with breathing difficulties.

[3] Percutaneous Endoscopic Gastrostomy tube is a feeding tube placed directly in the stomach. It is used to feed patients who have problems swallowing and or are prone to aspiration (breathing food or fluids in the lungs while eating and drinking).

Results

We did not substantiate:

- The patient received substandard quality of care and that the care received contributed to the patient's self-extubation and subsequent death.

We could not substantiate or refute:

- The telemetry alarms at the central nurses' station in the MICU were silenced or disabled when the patient became extubated.
- Personnel silenced or disabled the telemetry alarms at the central nurses' stations in the MICU and SICU.

We substantiated that:

- The facility's nursing peer review and investigational findings did not make any recommendations or document issues of concern related to the care the patient received and nursing actions.
- Policies and procedures to increase the safety and monitoring of patients in the medical and surgical intensive care units were implemented following the incident.

Our inspection found that facility staff (the intensive care managers, respiratory care services manager, risk managers, and performance improvement managers) reviewed the incident and developed performance improvement procedures. The MICU, SICU, and the Respiratory Care Services Department managers have implemented policies and procedures that establish responsibility and accountability for verifying and documenting all alarms related to patient safety and monitoring are functional. Additionally, following the incident, the Respiratory Care Services Department managers have implemented policies and procedures to verify and document the security of the endotracheal tube, to include cuff pressure, on all patients receiving ventilator-assisted mechanical respirations.

The Biomedical Engineering Department installed devices (metal cages) to prevent tampering, silencing, and disabling the telemetry alarms at the central nurses' station in the medical and surgical intensive care units. However, the design of the cages does not prevent disabling of the alarms.

Recommendations

Recommendation 1: We recommended that the facility report the incident to the VA National Center for Patient Safety to decrease the potential for poor patient outcomes.

Recommendation 2: We recommended that Biomedical Engineering Department reduce the width and length of the access opening on the metal cages surrounding the audio system to ensure that staff do not inadvertently render the system inaudible.

Recommendation 3: We recommended that managers ensure all nursing personnel are knowledgeable of the new policies and procedures.

Comments

The VISN and Facility Directors agreed with the findings and recommendations. The implementations plans are acceptable, and we will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 29, 2011

From: VISN Network Director (10N12)

Subject: **Healthcare Inspection – Quality of Care Issues, Edward Hines Jr. VA Hospital, Hines, Illinois**

To: Regional Director, Healthcare Inspections (54CH)

1. Please find attached Hines VAH response to the OIG review. Hines VAH has provided a response to each of the three recommendations presented.

2. If you have any additional questions or concerns, please contact Annette Van Bogaert, Performance Improvement Manager, 2-5652.

Victoria Brahm, Quality Management Officer

for and in the absence of

Jeffrey Murawsky, M.D.

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 29, 2011

From: Director, Hines VAH (578/00)

Subject: **Healthcare Inspection – Quality of Care Issues, Edward Hines Jr. VA Hospital, Hines, Illinois**

To: Regional Director, Healthcare Inspections (54CH)

1. Please find attached Hines VAH response to the OIG review. Hines VAH has provided a response to each of the three recommendations presented.

2. If you have any additional questions or concerns, please contact Annette Van Bogaert, Performance Improvement Manager, 2-5652.

(original signed by:)
Sharon Helman

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1: We recommended that the facility report the incident to the VA National Center for Patient Safety to decrease the potential for poor patient outcomes.

Concur **Target Completion Date**: September 27, 2010 and mid February 2011 in an addendum

Completed. The Patient Safety Manager reported the incident to the National Center for Patient Safety.

Recommendation 2: We recommended that Biomedical Engineering Department reduce the width and length of the access opening on the metal cages surrounding the audio system to ensure that staff do not inadvertently render the system inaudible.

Concur **Target Completion Date**: January 20, 2012

Biomed will reduce the width and length of the access openings on the metal cages surrounding the audio system.

Recommendation 3: We recommended that managers ensure all nursing personnel are knowledgeable of the new policies and procedures.

Concur **Target Completion Date**: November 5, 2011

Completed. Nursing staff (CMICU, CIU, and SICU) will receive an in-service regarding the central monitor alarms and we have included this as a competency.

Policies related to this issue will be reviewed at a staff and/or Committee meeting. A sign off sheet was attached to the policy for staff to sign once they read the policy.

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Acknowledgments	Verena Briley-Hudson, ARNP, MN, Project Leader Debra Boyd-Seale, Ph.D. Wachita Haywood, RN Judy Brown, Program Support Assistant

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