Administrative Closure
Failure to Recognize and Respond to a Patient in Crisis
South Texas Veterans Health Care System (671/00)
San Antonio, TX
MCI # 2013-03137-HI-0439

The VA Office of Inspector General Office of Healthcare Inspections received allegations from a confidential complainant about care at the South Texas Veterans Health Care System, San Antonio, TX (facility). The complaint alleged that a (b)(6) registered nurse (RN) working the night shift failed to identify the vital signs indicative of aspiration/air hunger, notify a physician of the patient's coffee ground emesis, and call the Dedicated Acute Assessment Rapid Response Team (DARRT).

We conducted an onsite review on June 26, 2013. We interviewed selected staff and reviewed the electronic health record of the patient subject of the allegations, policies and procedures, service-level competency folders, and VETPRO records.

The complainant's allegations involved the care of a (b)(3):38 U.S.C. 5701 active duty service member who was transferred from (b)(3):38 U.S.C. 5701,(b)(6) to the facility's Polytrauma Emerging Consciousness Program. The patient sustained significant injuries during an out-of-state training exercise including flail chest with pneumothorax, multiple facial and body fractures including thoracic spinal fracture, severe traumatic brain injury, and intracranial hemorrhage. The patient's consciousness was improving, and he was transferred to the acute inpatient polytrauma unit. Approximately 2 months after admission, the patient experienced a cardiac arrest and was transferred to the medical intensive care unit where he expired shortly thereafter, despite aggressive resuscitation and life support. An autopsy was offered to and declined by the family. The cause of death was documented as multisystem organ failure and acute respiratory distress syndrome.

We did not substantiate that a (b)(6) RN failed to recognize and respond appropriately to the patient's vital signs during the night prior to the patient's death. We interviewed staff involved in the patient's care and determined that:

- At 9 p.m. the night prior to the patient's death, he experienced an episode of emesis. The patient's RN observed the gastric contents and noted a large amount of undigested food particles, including what looked like the chocolate pudding he had eaten earlier. The gastric contents she saw did not have a coffee ground appearance.
- The patient's RN charted vital signs in the medical record that were taken by the restorative aide when the patient made uncontrolled repetitive movements that affected the accuracy of the equipment measuring the vital signs.

- The patient's RN was familiar with the patient, and in response to the reported vital signs, observed the patient closely throughout the night. DARRT was not called because the patient did not appear to be in distress and appeared to be sleeping comfortably. The RN reported not retaking the vital signs because up to that period of time the patient had similar periods of tachycardia and tachypnea that previously resolved spontaneously. The patient only slept 3–4 hours per night, and the RN did not want to interrupt his sleep.
- The following morning, the patient was in no apparent distress. He was sitting up and indicating he wanted to eat when he was observed by the restorative aide to become dusky in color; an RN immediately assessed him and called DARRT. The patient went into full cardiac arrest, was resuscitated, and was transported to the intensive care unit.

(b)(3) 38 U.S.C. 5705

Based on our review, we recommend administrative closure.

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

7/19/13