Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Suspicious Death, Delay in Surgery, and Failure to Obtain Preoperative Cardiac Workup

Harry S. Truman Memorial Veterans' Hospital Columbia, Missouri

Report No. 05-01372-60

January 25, 2006

VA Office of Inspector General
Washington, DC 20420

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

TO: Director, Harry S. Truman Memorial Veterans' Hospital

SUBJECT: Healthcare Inspection – Alleged Suspicious Death, Delay in Surgery, and Failure to Perform Preoperative Cardiac Evaluation, Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri

1. Purpose

To review allegations from an anonymous complainant regarding: a suspicious death following same-day surgery, delay in a patient's surgery, and failure to perform preoperative cardiac evaluation at the Harry S. Truman Memorial Veterans' Hospital.

2. Background

An anonymous complainant made allegations to the Office of Inspector General regarding three separate patients. Specifically, the complainant alleged that:

- On April 1, 2003, a patient had ambulatory surgery for a ureteral stent change and was discharged home the same day. The patient died the next day. An electronic Computerized Patient Record System (CPRS) note indicating the cause of death was not entered.

- On December 13, 2004, a patient entered the operating room (OR) at 1200. The patient was placed under anesthesia for approximately 1 hour and 40 minutes prior to the start of the surgery.

- On July 15, 2002, a patient had an elective surgical procedure performed and developed atrial fibrillation postoperatively. The patient did not have a preoperative cardiac assessment. The patient had a cardiac arrest at 0345 on July 17. Resuscitation efforts were unsuccessful, and the patient died at 0445.

3. Scope and Methodology

We reviewed the patient's hard copy medical records, CPRS records, Veterans Health Administration (VHA) and hospital policies and procedures, peer review documents, and other pertinent documentation.

We conducted a visit at the hospital on May 24–26, 2005 and completed telephonic interviews through November 2005. We interviewed staff in Quality Management (QM), Surgical Service, Anesthesia Service, administrative and clerical staff, the OR nurse manager, and the Chief of Staff, and analyzed medical examiner documents, OR schedules, peer reviews, and occurrence screen (OS) reports.

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

4. Inspection Results

Issue 1: A Patient's Suspicious Death Following Same-Day Surgery

A patient underwent outpatient right ureteral stent change for hydronephrosis[1] on April 1, 2003. The patient had a history of chronic renal insufficiency and coronary artery disease. The patient's March 20 preoperative electrocardiogram (ECG) showed a remote myocardial infarct, new when compared to an ECG from November 24, 2002. No progress note addressed these preoperative cardiac findings. The patient met discharge criteria and was discharged home with follow-up appointments in Primary Care, Nephrology, Urology, and General Surgery Clinics. The patient died at home the next day.

The ambulatory surgery nurse made a routine postoperative follow-up telephone call to the patient's home the day after surgery, but there was no answer. A follow-up letter was then mailed to the patient's home address. On April 30, a clinic clerk received a telephone call from a family member notifying the hospital of the patient's death on April 2. The clinic clerk notified the hospital's details clerk of the patient's death. The details clerk initiated an electronic message (e-mail) to the hospital's mail group of employees who need to be informed of patients' deaths, for purposes such as canceling appointments and pending prescriptions and noting hospital bed availability. There was no documentation that clinical or QM staffs were notified of the patient's death, and no review was done. According to the funeral home director, no autopsy was performed. The funeral home provided the hospital with a copy of the patient's death certificate signed by the Medical Examiner.

[1]Distention of the pelvis and calices of the kidney with urine, as a result of obstruction to the ureter.

Conclusion

We substantiated the allegation that there was a suspicious death following same-day surgery. Although the abnormal ECG was not addressed, we found no evidence to suggest that a preventable cardiac event was responsible for his death.

Recommended Improvement Action 1. We recommend that the hospital director ensure that (a) appropriate hospital staff are notified of patient deaths and deaths are documented and reviewed according to policy and (b) abnormal preoperative tests are addressed.

Issue 2: Delay in a Patient's Surgery

On December 13, 2004, a patient was scheduled to have two surgical procedures. The anesthesia preoperative review for the first procedure was done at 1200. The patient entered the operating room at 1235 and that procedure (ureteral stent placement) began at 1255, performed by urologists. The second operation (sigmoid colectomy), performed by general surgeons, began at 1340.

Conclusion

We did not substantiate the allegation that a patient was placed under anesthesia for approximately 1 hour and 40 minutes prior to the start of surgery.

Issue 3: Failure to Obtain Preoperative Cardiac Workup

On July 15, 2002, a patient had elective surgery and developed atrial fibrillation postoperatively. An ECG done on July 11 was abnormal. In addition, the patient had a history of aortic stenosis,[2] and "aortic valve disorder" was listed on the active problem list. Consultation with Cardiology was not requested. On July 16, after the patient developed atrial fibrillation, Cardiology consultation was requested and a cardiologist saw the patient that day. Echocardiography revealed severe aortic stenosis.

On July 17 the patient arrested and resuscitative efforts were unsuccessful. The autopsy report shows that the patient's immediate cause of death was pulmonary edema. The anesthetist who performed the preoperative assessment of the patient reported that he looked in the medical record for reports of any prior cardiac testing (other than ECGs) but found none. When he learned after the patient's death that echocardiography done in 2000 showed severe aortic stenosis, he was still unable to locate the report in CPRS until he was told specifically where to find it.

[2]Narrowing of the orifice of the aortic valve.

Conclusion

The patient's history of aortic stenosis should have prompted a preoperative cardiac evaluation. Further, although aortic valve disease was included in the patient's problem list, the prior echocardiograph was not available where expected in CPRS.

Recommended Improvement Action 2. We recommend that the hospital director (a) confer with Regional Counsel regarding the need to inform the patient's family of the findings and (b) ensure that echocardiography reports are viewable in the medical record where they can be readily retrieved by diligent providers, or that providers are educated about where to locate such reports.

4. Hospital Director Comments

I concur with the findings and recommendations of this hotline review. Recommended Improvement Action 1 has been fully implemented. Recommended Improvement Action 2(a) will be addressed with Regional Counsel as suggested. Recommendation 2(b) has been fully implemented.

5. Assistant Inspector General for Healthcare Inspections Comments

The Hospital Director agreed with the findings and recommendations and provided acceptable improvement plans. We will follow up on planned actions until they are completed.

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

Reference List

American College of Cardiology/American Heart Association, *Guideline for Perioperative Cardiovascular Evaluation for Noncardiac Surgery—Executive Summary,* Circulation, 2002; 105:1257-1267.

Dorland's Illustrated Medical Dictionary, 1999, 28th Ed. Philadelphia, PA: W.B. Directive Saunders Company.

VHA Directive 2004-036, Mortality Assessment, July 20, 2004.

VHA Directive 2004-051, Quality Management (QM) and Patient Safety Activities that can Generate Confidential Documents, September 28, 2004.

VHA Directive 2204-054, Peer Review for Quality Management, September 29, 2004

Appendix A

Hospital Director Comments

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

Recommended Improvement Action 1. We recommend that the hospital director ensure that:

(a) appropriate hospital staff are notified of patient deaths and deaths are documented and reviewed according to policy,

Concur **Target Completion Date:** June 2005

QM clinical reviewers were added to the 'death' notification mail group. Deaths are reviewed in accordance with VHA Directive 2004-054, dated September 29, 2004.

and (b) abnormal preoperative tests are addressed.

Concur **Target Completion Date:** Implemented and ongoing

Fully implemented.

Recommended Improvement Action 2. We recommend that the hospital director:

(a) confer with Regional Counsel regarding the need to inform the patient's family of the findings;

Concur **Target Completion Date:** January 2006

Risk Manager will confer with Regional Counsel regarding disclosure of findings to patient's family.

and (b) ensure that ECG reports are viewable in the medical record where they can be readily retrieved by diligent providers, or that providers are educated about where to locate such reports.

Concur **Target Completion Date:** December 2005.

Echocardiograms are located under the Report tab in CPRS. A CPRS reminder will be sent to all providers instructing them on how to locate these reports.

Appendix B

OIG Contact and Staff Acknowledgments

OIG Contact	Verena Briley-Hudson, M.N., R.N. Director, Chicago Office of Healthcare Inspections (708) 202-2672
Acknowledgments	Paula Chapman, CTRS Wachita Haywood, M.S., R.N. Jerome Herbers, M.D. George Wesley, M.D.

Appendix C

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