Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Quality of Care Issues
Jesse Brown VA Medical Center
Chicago, Illinois

Report No. 06-00464-06 **October 18, 2006**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Call the OIG Hotline – (800) 488-8244

Executive Summary

The VA Office of Inspector General received allegations from an anonymous complainant regarding lack of resident supervision, patient abuse, substandard quality of care, and administrative failures at the Jesse Brown VA Medical Center in Chicago, IL. The complainant alleged:

- An intern placed central lines in two patients without supervision and without being properly educated.
- A patient's treatment plan was controversial.
- A few years ago, the Surgical Service left an instrument in a patient's abdomen.
- An altercation occurred between a hospitalized patient and an employee.
- A hospital employee had an acute asthma attack and died in the emergency room.
- A physician responded to an anesthesia code and had difficulty intubating the patient.
- A staff physician did not fulfill the terms of a special pay agreement with no consequences of penalty or repayment of funds.

We conducted an on-site inspection and interviewed medical center leadership, physicians, nurses, allied healthcare personnel, and administrative support employees. We reviewed Veterans Health Administration (VHA) directives, medical center policies, quality management documents, patient medical records, and other documents related to these allegations.

We did not substantiate lack of resident supervision, patient abuse, substandard quality of care, or administrative failures. We did substantiate the allegation that Surgical Service left an instrument in a patient's abdomen. This incident was reviewed at that time by VHA's Office of the Medical Inspector. We also substantiated that an altercation occurred between a patient and an employee; the medical center responded appropriately. We made no recommendations.

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

TO: Director, Veterans Integrated Service Network (10N12)

SUBJECT: Healthcare Inspection – Quality of Care Issues, Jesse Brown VA Medical Center, Chicago, Illinois

Purpose

The Department of Veterans Affairs, Office of Inspector General (OIG), Office of Healthcare Inspections reviewed allegations regarding lack of resident supervision, patient abuse, substandard quality of care, and administrative failures at the Jesse Brown VA Medical Center (referred to as the medical center).

Background

Located on the west side of Chicago, Illinois, the medical center consists of a 188-bed acute care facility and 4 community based outpatient clinics in Chicago, Chicago Heights, and Beverly, Illinois; and in Crown Point, Indiana. The medical center has affiliations with the Feinberg School of Medicine of Northwestern University and the University of Illinois at Chicago Medical School.

On November 15, 2005, an anonymous complainant submitted allegations to the OIG Hotline regarding lack of resident supervision, patient abuse, substandard quality of care, and administrative failures. The complainant alleged:

- In October 2005, an intern placed a central line in two Medical Intensive Care Unit/Coronary Care Unit (MICU/CCU) patients (hereafter called patient A and patient B) and failed to remove the guide wire from both patients. As a result, consults were sent to Interventional Radiology to remove the guide wires. The complainant alleged that both procedures were performed without supervision and that the intern had not been properly educated in the placement of central lines.

- Due to lack of supervision and negligence, the intern unnecessarily placed central lines in patient A and patient B.

- Patient A's diagnosis was questionable. Consequently, the decision to address his hyponatremia (low sodium) by placement of a central line was controversial compared to an alternative of fluid restriction and discontinuation of the medication carbamazepine. On a later date (subsequent to hospitalization), the patient's attending psychiatrist was negligent when she restarted carbamazepine.

- A few years ago, the Surgical Service left an instrument in a patient's abdomen.

- In October 2005, an altercation occurred between a hospitalized patient and an employee.

- On August 21, 2005, a hospital employee had an acute asthma attack and went into respiratory failure. The employee died in the emergency room (ER). The patient's treating physician was working in the ER as a "moonlighting emergency room doctor."

- On August 25, 2005, a moonlighting fellow was on call carrying the anesthesia code beeper. The fellow responded to an anesthesia code and had difficulty intubating the patient. The complainant alleged that the fellow felt strongly that because of their expertise with intubations, the anesthesia service should be on call in the facility during off hours. The fellow reportedly ceased working at the VA because he did not want to stay and fight with the administration over this issue.

- A former staff physician resigned in June or July 2000, breaking a contract agreement with the VA for Special Pay/Bonus.

Scope and Methodology

We conducted an on-site inspection at the medical center January 23–27, 2006. We interviewed medical center leadership, physicians, nurses, allied health care personnel, and administrative support employees. On March 9, we interviewed the pathologist who had performed the autopsy on the patient who died in the ER in August 2005. This patient's Medical Certificate of Death was reviewed. We reviewed Veterans Health Administration (VHA) directives, medical center policies, quality management documents, and patient medical records related to these eight allegations. We reviewed personnel records related to the alleged altercation between a patient and an employee. We reviewed the Office of the Medical Inspector (OMI) report, *Review of the Delivery of Surgical Services, Veterans Integrated Service Network 12, VA Chicago Healthcare System,* issued February 27, 2004.

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

Findings

Case History: Patient A

Patient A, a 60-year-old male with a history of hypertension, chronic obstructive pulmonary disease, and chronic bilateral knee and low back pain, had been followed at the Mental Health Clinic since 2002 for anxiety, insomnia, and depressive symptoms. In July 2004, the patient reported a history of mood shifts. His psychiatrist added the anticonvulsant mood stabilizer valproate to his regimen of antidepressant and anti-anxiety medications. In September 2004, the patient reported having fallen numerous times shortly after standing up from a sitting position or lying down. The patient's psychiatrist referred him to the ER for evaluation of his blood pressure status. In the ER, the patient's EKG was noted as normal sinus rhythm with non-specific T wave changes. His blood pressure was orthostatic and the episodes of falling were attributed to a recent change in his antihypertensive regimen and a decreased fluid intake. He received intravenous fluid hydration in the ER and was admitted to the telemetry unit for observation and to rule out a cardiac origin. His sodium at the time of admission was 124 (normal range 136–145) and potassium level was 3.1 (normal 3.5–5.1). A medicine resident noted that the patient had been hyponatremic for more than a year. His sodium level in July 2004 had been 131, with potassium of 3.2.

In the hospital, the patient was tested for hypoadrenalism, which was reportedly negative. His thyroid-stimulating hormone level was also checked and was within normal limits. His serum osmolality[1] was slightly low. A computerized tomography (CT) scan of the head was negative.

During a September 22, 2004, post-hospitalization Primary Care Clinic follow-up appointment, the patient's physician noted that he may have had syndrome of inappropriate antidiuretic hormone (SIADH). Because the patient had an extensive history of smoking, the primary care physician ordered a CT scan of the chest to evaluate for a pulmonary malignancy with an associated paraneoplastic syndrome which could cause SIADH. In addition, the patient was referred for evaluation by an endocrinologist. The progress notes indicate that the CT scan of the chest did not show evidence of a pulmonary malignancy. The Endocrine Service consultant did not feel that the hyponatremia was due to SIADH or adrenal abnormality.

At an Urgent Care Clinic appointment in September 2005, the patient's sodium was 122. He reported drinking about 9 or 10 12-ounce cups of water per day. Serum osmolality and urine sodium levels were repeated. Psychogenic polydipsia[2] and medication-induced hyponatremia were noted as possible causes of his low sodium. The patient was

[1] A serum osmolality test measures the amount of chemicals dissolved in the fluid portion of blood (serum); it is done to evaluate electrolyte and water balance.
[2] Polydipsia is excessive thirst.

instructed to reduce his fluid intake, and his physician in Primary Care Clinic planned to discuss with his psychiatrist whether any of his psychiatric medications, especially valproate, could be causing his hyponatremia. At a September 2005 Psychiatry Clinic appointment, the patient's psychiatrist tapered him off the valproate, started him on the anticonvulsant mood stabilizer carbamazepine, and scheduled a return to clinic in 1 week. A repeat sodium level on October 5 was 113. His psychiatrist discontinued the carbamazepine and referred the patient to urgent care for evaluation.

In the ER, a repeat sodium level was 110. His blood pressure and pulse were 120/72 and 89 lying down, 120/78 and 103 sitting, and 125/68 and 107 standing. He was admitted to the MICU for further monitoring. The medicine resident in the ER noted, "Given severely low lab, will get CT head to rule out cerebral edema (although no sx [symptoms]). If +, will start hypertonic saline. If –, will fluid restrict, hold meds, follow Na [sodium] in MICU overnight to ensure stabilization. Seen and discussed with attending. Discussed with MICU resident."

In the admission note, the medicine resident on call in the MICU/CCU noted that the patient appeared hypovolemic[3] by exam though borderline orthostatic[4]. The patient's arterial blood gas (ABG) was indicative of a respiratory alkalosis with a metabolic acidosis. Carbamazepine level was 7 (normal range 4–10). The medicine resident noted a differential diagnosis that included SIADH, psychogenic polydipsia, and possible side effect from several of his medications, including the carbamazepine, the antidepressant fluoxetine, and the antihypertensive lisinopril. In the MICU/CCU on the night of admission, the patient was noted to be asymptomatic. The plan was to restrict his free water intake and to place a central line should he become symptomatic, in which case he would be treated with intravenous hypertonic saline. The medicine resident's note states that the patient was discussed with the MICU/CCU fellow.

An intern on call in the MICU/CCU placed a central line in the patient's right femoral vein. The procedure note, timed 00:31 on October 6, indicates that the intern was assisted by the MICU/CCU medicine resident. The patient reportedly did well overnight with fluid restriction and holding several of his medications. His sodium increased to 116. A chest x-ray (CXR) showed that the guide wire had been left inside the patient during insertion of the central line into the right femoral vein. The patient consented to have the guide wire removed by the interventional radiology service. The interventional

[3] Hypovolemic shock is an emergency condition in which severe blood and fluid loss makes the heart unable to pump enough blood to the body.
[4] Orthostasis means upright posture; hypotension means low blood pressure. Orthostatic hypotension has symptoms of dizziness, faintness, or lightheadedness which appear only on standing, and which are caused by low blood pressure.

radiologist noted no complications and no abnormality on a post procedure Superior Vena Cava [SVC][5] gram.

On October 7, an endocrine consultant noted that the patient's hyponatremia was "likely multifactorial 2/2 [secondary to] multiple psychiatric meds which may cause as well as psychogenic polydipsia although expect UOsm [urine osmolality] to be lower than found on admission." The endocrine consultant recommended continuing fluid restriction, starting the medication demeclocycline, having psychiatry review the psychotropic regimen, "as tegretol may cause Pseudo-SIADH like picture…," and scheduling a follow-up appointment at Endocrine Clinic for 2–4 weeks following discharge. A psychiatry resident consultant recommended discontinuing all prescribed psychiatric medications and re-introducing medications slowly once sodium levels increased to an acceptable range. The sodium level on October 7 was 125. A post-hospital follow-up appointment was scheduled with psychiatry for October 11.

On October 13, the patient's outpatient psychiatrist re-started the mood stabilizer carbamazepine. The psychiatrist saw the patient again on October 18, at which time his sodium level was 124.

On October 27, the patient was seen for an unscheduled visit by his psychiatrist for mental status changes, including disorientation to time and disorganization. Prior to this visit, the patient's carbamazepine had been discontinued, and he had been restarted on valproate. He was referred to the ER for evaluation where his sodium level was noted to be 134 and his potassium level 3.9, which are essentially within normal limits. However, the patient's serum urea nitrogen level was 27 (normal range 7–21), indicative of pre-renal azotemia[6], and his serum creatine level was 2.6, indicative of acute renal failure. The patient was admitted to the general medicine service. The general medicine attending physician noted that the patient was dehydrated, likely from poor oral intake. He noted that the patient's fractional excreted sodium level was low, his serum sodium level was 134, and he was orthostatic. A renal ultrasound was "negative," and the patient's renal failure improved with fluids.

Case History: Patient B

The patient, an 80-year-old male, had a history of colon cancer, small bowel obstruction, hypertension, and dementia. He presented to the ER on October 2, 2005, with a 1-day history of progressive decline in mental status. The previous day he had been less active and had diminished oral intake. In the ER, he was febrile, tachycardic (elevated heart rate), had an elevated white blood cell count of 32.5K/µl (normal 4–11), a hemoglobin of

[5] The superior vena cava is a large, short vein that carries de-oxygenated blood from the upper half of the body to the heart's right atrium.
[6] Prerenal azotemia is an abnormally high level of nitrogen-type wastes in the bloodstream; it is caused by conditions that reduce blood flow to the kidneys.

11.2 g/dl (normal range 13–17), and his arterial blood gas was indicative of profound hypoxia[7] and a respiratory alkalosis[8]. He was noted to withdraw as a response to pain and have a gag reflex but was otherwise unresponsive. He was intubated in the ER, and a central line was placed by a medicine resident. The patient's blood was cultured, and he was started on broad spectrum antibiotics and admitted to the MICU/CCU. A nurse in the MICU/CCU noted pulsatile flow and questioned whether the catheter had been inadvertently placed in the left subclavian artery rather than in the left subclavian vein. A vascular surgical consultant removed this central line and placed an internal jugular catheter, given the patient's presumed sepsis and the need for central venous access.

An October 3, a CT scan of the head showed a new left parietal hemorrhagic laminar infarction when compared with an August 2004 head CT scan. On October 4, the patient's hemoglobin level had declined to 7.4g/dl. A neurology consultant felt that the patient's ongoing mental status changes were most likely due to sepsis and anemia. The neurology consultant noted a rhythmic twitch of the right corner of the patient's mouth and recommended an EEG and initiation of the anticonvulsant phenytoin. Although the CT scan changes were noted to be unlikely to account for the level of mental status changes, secondary seizures were a consideration.

On October 6, at 2:30 a.m., the medicine intern removed the right internal jugular line that had been placed on October 3 and inserted a right femoral vein catheter. The patient tolerated the procedure well. The intern's progress note, written later that morning, indicated that the October 3 blood cultures were growing Staphylococcus Aureus (S. Aureus)[9], and blood cultures from October 4 were also growing gram positive cocci in clusters felt most likely to be S. Aureus. The intern noted that the right internal jugular line had been replaced earlier that morning since the patient was bacteremic.[10] However, a chest x-ray performed on the morning of October 6 revealed that the wire that was used to guide placement of the catheter was left inside the patient. The patient was referred to interventional radiology for removal of the guide wire. The radiologist removed the guide wire and no complications were noted. No abnormality was noted on a post-procedure SVC exam. The Infectious Disease (ID) Service consultant's progress note, written later that day, recommended removal of all intravenous lines placed prior to October 4. This included the right internal jugular catheter placed on October 3 that the intern had already replaced in the early hours of October 6.

[7] Hypoxia is the reduction of oxygen in tissues below normal levels.
[8] Respiratory alkalosis is caused by lower carbon dioxide levels.
[9] Staphylococcus aureus is a bacterium, frequently living on the skin of a healthy person, that can cause illnesses ranging from minor skin infections to life-threatening diseases such as pneumonia, meningitis, endocarditis, toxic shock syndrome, and septicemia.
[10] Bacteremic means having bacteria in the bloodstream.

Allegation 1: Central Line Guide Wires, Resident Supervision, and Resident Education

Patient A: As described in the case history above, the intern failed to remove the guide wire from the patient after inserting a central line. The guide wire was removed by an interventional radiologist without complication. Post removal SVC gram was without abnormality. The MICU/CCU Medical Director reported that the patient did not experience subsequent complications or sequellae related to the incident following removal of the guide wire. The procedure note for the central line placement states that the intern was assisted by a third-year resident. The MICU/CCU Medical Director reported that in his interactions with this intern, he found the intern to be appropriately knowledgeable in the placement of central lines for level of training. A memorandum to the medical center Chief of Staff dated November 1, 2005, stated that the senior resident, who supervised the intern during placement of the central line, "has placed enough central lines in the past to be considered competent by most standards set forth by hospital credentialing committees...." In addition, the MICU/CCU Medical Director reported that the senior resident had not demonstrated a previous history of problems with central line placement.

Patient B: The progress notes indicate that on October 6, the intern failed to remove the guide wire after placing the right femoral central line catheter in this patient. The guide wire was later removed without complication by an interventional radiologist. The MICU/CCU Medical Director reported that following removal of the guide wire, the patient did not experience subsequent complications or sequellae related to the incident. The intern who placed this central line was the same intern who placed the central line discussed in patient A. From the timing of the progress notes, it appears that both incidents occurred within a few hours of each other in the late evening/very early morning of October 5–6. The MICU/CCU Medical Director recalled that the incidents may have occurred within the same hour. He reported that the senior resident believed the intern was competent in placement of central lines because the intern had successfully performed this type of procedure in the past, and the third-year resident had just supervised the intern in placement of a central line. As a result, the senior resident was reportedly nearby but did not directly supervise the intern during the placement of this central line.

Both incidents were reported through the medical center's Patient Incident Reporting System, followed up with quality management reviews, and were further reviewed by the Chief of Staff in accordance with VA policies and procedures. The MICU/CCU Medical Director reported that the intern had been educated on the proper procedures for placing central lines. In the memorandum to the Chief of Staff dated November 1, 2005, the MICU/CCU Medical Director noted that loss of a guide wire is a known but infrequent complication of the procedure, "…it should be noted that all central line guide wires have a design flaw which allows such a complication to occur." The MICU/CCU Medical Director concluded that "…the intern's inexperience contributed to this complication."

He recommended implementation of a centralized process of credentialing and maintaining clinical competence in central line placement and stressing the need for senior residents to be more vigilant when supervising junior house staff during this procedure.

The MICU Medical Director also commented that credentialing and maintenance of clinical competence with central line placement is an ongoing problem in all hospitals. He reported that one of the medical center's academic medical center affiliates is in the process of developing a clinical competence module and interactive teaching device in order to credential house staff (interns and residents) and to teach medical students.

Conclusion: In October 2005, an intern in the MICU/CCU failed to remove a guide wire during placement of a right femoral central line in patient A. The guide wire was later removed by an interventional radiologist. The patient did not experience subsequent injury or complications. The intern was supervised by a senior resident. We did not substantiate the allegation that the intern performed the procedure unsupervised.

The intern placed a central line in patient B and also failed to remove the guide wire. The patient did not experience subsequent injury or complications. We substantiated that the intern was not supervised during placement of this central line.

We did not substantiate the allegation that this intern had not been educated on the proper procedures for placing central lines.

Allegation 2: Unnecessarily Placed Central Lines

Patient A: The patient was referred to the medical center ER because his sodium level was 113. The plan was to restrict the patient's free water intake and to place a central line so that if he became symptomatic, there would be ready access for treatment with intravenous hypertonic saline. The medicine resident's note states that the patient was discussed with the MICU fellow.

The MICU Medical Director told us that, given the potential risks associated with a very low sodium level, the patient's borderline orthostatic hypotension, and the possibility that he would require intravenous hypertonic saline, it would be usual in this medical center's MICU/CCU to establish central venous access. He further explained that hypertonic saline is caustic to veins when administered peripherally and a central venous route is the preferred route of administration.

Patient B: The patient was critically ill at the time of his admission to the MICU. On October 6, the right internal jugular line that had been placed on October 3 was removed and replaced by a medical intern in the MICU. The intern's progress note from October 6 indicated that the right internal jugular central line had been replaced earlier that morning because the patient was bacteremic. The Infectious Disease Service consultant recommended removal of all intravenous lines placed prior to October 4. As

central intravenous lines can be a significant source of infection, it would be usual practice to replace an existing central line with a new central line in a patient who becomes bacteremic. In addition, it would be usual in a MICU setting for an intubated, severely ill patient with altered mental status to need central venous access for fluids, medications, and nutritional support.

Conclusion: We did not substantiate the allegation that due to negligence and lack of supervision, the intern unnecessarily placed a central line in these patients. Given patient A's sodium level, the overall clinical scenario, and the uncertainty regarding etiology, establishment of central venous access in this patient does not appear unreasonable. Replacement of patient B's central line on October 6 appeared clinically indicated and appropriate.

Allegation 3: Questionable Diagnosis and Negligence

Patient A: The complainant alleged that in October 2005, the patient's diagnosis in the MICU was questionable; and thus the decision to place a central line was questionable, compared with restricting fluids and discontinuing the patient's carbamazepine. The complainant further alleged that the patient's psychiatrist was negligent in restarting carbamazepine at a date subsequent to the patient's October 5 hospitalization.

The patient had a greater than 1-year history of hyponatremia. He had undergone several tests to work up his hyponatremia during a previous medical center admission in September 2004. He had been seen by the Endocrinology Service who noted that his low sodium was not likely due to SIADH or adrenal abnormality, but did not determine a specific etiology.

The Endocrinology Service consultant saw the patient in MICU/CCU on October 7 and recommended continuing fluid restriction, starting the medication demeclocycline, having psychiatry review the psychotropic regimen, "as tegretol may cause Pseudo-SIADH like picture," and scheduling an appointment at Endocrine Clinic for 2–4 weeks following discharge. Although the patient's sodium increased in the MICU with fluid restriction and discontinuance of several of his medications, the patient was noted to have borderline orthostatic hypotension in the ER, and a definitive etiology for his hyponatremia had not been determined at the time of admission to the medical center. Since the October 2005 admission, the patient has been treated in the ER on at least two occasions for dehydration in the presence of an apparently normal sodium level, suggesting that fluid and electrolyte balance in this patient may be delicate.

In September 2005, the patient had been switched to carbamazepine from valproate due to concern that valproate was causing his low sodium, which at the time decreased to 122. We interviewed the patient's outpatient psychiatrist, who has followed the patient since 2003. She reported that the patient appeared to have experienced a better response with carbamazepine than with valproate. The decision to restart the carbamazepine on

October 13 was based on her clinical judgment. She reported that she discussed with the patient the potential for carbamazepine to lower sodium levels and the importance of closely monitoring his sodium level.

Conclusion: We could not substantiate that the decision to place a central line in anticipation of correcting the patient's low sodium with hypertonic saline resulted from questionable diagnosis. A definitive etiology for the patient's low sodium was not clear at the time of admission to the MICU. His subsequent admissions to the hospital in late October and mid-November appeared related to fluid status and dehydration and unrelated to having been restarted on carbamazepine.

We did not substantiate the allegation that the attending psychiatrist was negligent in restarting carbamazepine subsequent to the October 5 admission. During the time interval in which the patient was restarted on carbamazepine, his sodium level did not decrease. The decision to retry the carbamazepine was based on the clinical judgment of a psychiatrist who had longitudinal experience with treating this patient over a 3-year period.

Allegation 4: An Instrument Was Left in a Patient's Abdomen During Surgery

The OMI conducted a thorough investigation of this incident in November 2003, issued a report, *Review of the Delivery of Surgical Services,* dated February 27, 2004, and made 19 recommendations. We reviewed this report and the medical center's subsequent corrective actions and follow-up reports to the OMI. The ongoing documentation that we inspected indicated that medical center managers have taken action to correct identified deficiencies.

Conclusion: While we substantiated the allegation that Surgical Service left an instrument in a patient's abdomen, this incident occurred in November 2003 and was reviewed fully by the OMI at that time. We do not make any recommendations regarding this issue.

Allegation 5: Patient and Employee Altercation

On October 12, 2005, an employee was involved in an altercation with a patient in the ER. According to medical center documentation, the employee was witnessed engaged in a verbal altercation with the patient because the patient was requesting a meal after a lengthy wait in the ER. The altercation escalated into physical contact. The employee was witnessed grabbing the patient around the neck and pushing the patient into a utility room. As a result, the patient fell over chairs and was found slumped on a floor against a wall.

During an interview with the Chief of Staff, we were informed that immediate measures were taken to care for the patient, and immediate action was taken to ensure patient

safety. The employee was appropriately taken out of all patient care responsibilities. After the medical center's investigation, appropriate action was taken against the employee.

Conclusion: We substantiated that an altercation occurred between a patient and an employee in October 2005. The medical center responded appropriately to ensure patient safety at that time.

Allegation 6: Medical Center Employee ER Care

A 63-year-old medical center employee was brought to the ER between 7:30 a.m. and 7:35 a.m. by a co-worker via wheelchair for severe shortness of breath. The patient had a history of asthma since childhood and had been intubated on at least two occasions. On presentation to the ER, the triage nurse noted the patient to be in respiratory distress with use of all accessory muscles. Initial pulse and blood pressure were noted as 40 and 108/54 with a pulse oximetry of 88 percent. Upon arrival to the ER, the patient was described as "…frantic and unable to catch her breath." The patient was treated with oxygen and placed on a cardiac monitor. The patient's pulse oximetry decreased to 65 percent, pulse was 38, and a sinus rhythm was present on the cardiac monitor. Breathing was reportedly agonal, and the patient was losing consciousness. The patient became unresponsive, and pulses could not be appreciated. At 7:40 a.m., a code was initiated and the patient was intubated. The ER physician on duty, who was moonlighting at the medical center rather than a full-time staff member, noted that humidified air was observed in the endotracheal tube and faint breath sounds were heard bilaterally. The patient quickly developed pulseless electrical activity and epinephrine was given initially through the endotracheal tube and then through the IV[11] once IV access was established. The patient received multiple doses of epinephrine and atropine in addition to sodium bicarbonate and a dose of solumedrol. The patient developed a pulse and junctional rhythm. Her systolic blood pressure was greater than 100 and oxygen saturations were 100 percent.

The patient's heart rate again dropped to less than 30, pulses were not palpable, and the oxygen saturation dropped to less than 60 percent. The monitor indicated pulseless electrical activity, and CPR was reinitiated. A concern arose that the patient's abdomen may have become distended. A respiratory therapist reportedly noted that the patient, who was obese, had become harder to bag, and her abdominal area was getting larger. The endotracheal tube was removed, and the patient was re-intubated. Placement of the endotracheal tube was confirmed with the presence of bilateral breath sounds and a carbon dioxide monitor. The patient received atropine, epinephrine, and bicarbonate. In addition, the beta-agonist albuterol was given through the endotracheal tube, and a dopamine drip was initiated. The patient was noted to be in ventricular fibrillation and was defibrillated. A junctional cardiac rhythm was briefly maintained before the patient

[11] IV is an abbreviation for "intravenous," meaning within a vein.

became bradycardic and then re-developed pulseless electrical activity. The patient never regained a rhythm, and after 1 hour of effort and multiple doses of medication, the patient was pronounced dead.

We interviewed physicians, nurses, and a respiratory therapist involved in the incident, and we reviewed a quality management review and the patient's medical record. An autopsy was performed 2 days later, and the death was felt most likely due to an arrhythmic event. The pathologist reported that he did not find any evidence of esophageal trauma. The final autopsy diagnoses were:

IA. Clinically acute bracycardia.

IB. Cardiomegaly and left ventricular hypertrophy.

IC. Coronary vessels with no atherosclerosis.

II. Pulmonary congestion and edema.

III. Hepatic congestion.

Conclusion: We did not substantiate the implication that the ER physician's status as a moonlighter (rather than a full-time ER physician) affected this patient's outcome. The patient went into cardiopulmonary arrest very shortly after arriving in the ER. A code blue was called, and staff responded quickly and appropriately. Despite the efforts of the code team, the patient died.

Allegation 7: Anesthesia Services on Off Tours of Duty

We interviewed the Chief of Staff and a former ER moonlighting physician. Effective July 1, 2004, the ER attending Medical Officer of the Day was designated responsibility for out-of-operating room emergency airway management (for example, intubation during cardiac arrest) in the evening and nighttime hours. The Anesthesiology Department will continue to cover all airway-related problems and consults in the daytime hours and is available during nighttime hours for management of urgent and non-emergent airway problems. The decision to place the responsibility of emergency airway management during evening, night, holiday, and weekend hours was made in order to comply with mandated reductions in resident working hours. Prior to July 2004, the surgical resident on call was responsible for emergency airway management during evening, night, holiday, and weekend hours.

The former moonlighter reported that, in August 2005, he was confronted with a difficult intubation on one of the medical units. He called the on-call anesthesia resident, but there was a delay in response. Because of the delay, the moonlighter reported that he maintained adequate ventilation by handheld bag mask ventilation. After querying staff, the moonlighter told us that he believed that a clerk had paged the anesthesia resident to

call the extension for the ER rather than for the unit that the patient was on. The anesthesia resident was paged again, responded, came to the unit, and intubated the patient.

ER physicians and moonlighters at the medical center are certified in Advanced Cardiac Life Support (ACLS), which includes airway management training. The moonlighter told us that different physicians have different levels of comfort with different procedures. His decision not to continue in the role of a moonlighter at the medical center was a personal choice, based on his own personal comfort level with intubations, and was not based on discord or the complainant's allegation that "he did not want to fight with the administration."

In August 2005, VHA issued a Directive, *Out-Of-Operating Room Airway Management*, that addresses the appropriate competencies of those who perform urgent and emergent airway management outside of VHA facility operating rooms. This policy directed each inpatient facility to have a written policy in effect by December 1, 2005, regarding out-of-operating room airway management and ensuring the competency of staff performing this task. In accordance with the VHA directive, the medical center established an "Out-Of-Operating Room Airway Management" policy. The Chief of the Anesthesiology Service was tasked with administering the components of the training and competencies. Consistent with the VHA directive, this policy lists requirements for competency. ACLS certification itself is not adequate to satisfy these requirements. Emergency airway management provider training sessions and procedures for demonstrating competency have been put in place by the medical center. The medical center provided us with a list of ER physicians and moonlighters who had met the competency requirements as of February 2006.

Conclusion: We did not substantiate the allegation that a former moonlighter no longer works for the medical center because he did not want to fight with the administration over the policy for coverage of airway management during evening, weekend, and holiday hours. The medical center had put in place an "*Out-of-Operating Room Airway Management*" policy consistent with a VHA directive and has put in place a procedure for monitoring physician compliance with the policy.

Allegation 8: Physician Employment Contract

We consulted Human Resources Management Services' policies in the course of our review of the allegation regarding a staff physician's contract agreement.

Conclusion: We did not substantiate the allegation. The physician fulfilled the employment time requirement as defined by the Special Pay Agreement.

Recommendations

We made no recommendations.

VISN Director's Comments

The VISN Director agreed with the report findings and conclusions. See Appendix A (page 15) for the Director's comments.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: July 27, 2006

From: VISN 12 Network Director (10N12)

Subject: **Draft Report –** Healthcare Inspection – Quality of Care Issues, Jesse Brown VA Medical Center, Chicago, Illinois – Project Number: 2006-00464-HI-0196

To: Director, Management Review (10B5)

1. The draft report prepared by the Director, Chicago Regional Office of Healthcare Inspections, Office of Inspector General (OIG) was reviewed and all conclusions were concurred. No additional comments will be submitted with this draft report.

2. We wish to thank the OIG team, headed by Verena Briley-Hudson, Director, Chicago Regional Office of Healthcare Inspections, for their comprehensive review that was completed in a professional and thorough manner.

James W. Roseborough
Network Director

Appendix B

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Appendix C

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