Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Post-Operative Paralysis
Overton Brooks VA Medical Center
Shreveport, Louisiana

Report No. 10-03462-190

June 8, 2011

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: http://www.va.gov/oig/contacts/hotline.asp)

Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to determine the validity of an allegation regarding post-operative paralysis at the Overton Brooks VA Medical Center (the medical center), Shreveport, LA. A complainant alleged that a patient could not move his lower extremities after the insertion of an epidural catheter (small hollow tube used to inject anesthetic between the spinal canal and spinal cord). The complainant believed that the catheter caused the patient's paralysis.

We did not substantiate the allegation. However, we found that the patient's paralysis may have resulted from a prolonged period of hypotension (low blood pressure) in the intensive care unit (ICU). We concluded that the hypotension was poorly monitored and should have been treated more aggressively.

During our review, we found that ICU nursing staff did not document required patient assessments. There was no documentation of the mean arterial pressures needed to adjust medications prescribed for low blood pressure, no documentation of the epidural catheter or of neurological assessments, and inconsistent documentation of verbal orders and administered medications. In addition, we found that the medical center's system of reporting and evaluating adverse events needed improvement.

We recommended that the Medical Center Director ensure that (1) patients in the ICU are assessed appropriately and patient care activities are consistently documented, and (2) processes are in place for reporting and evaluating adverse events.

The VISN and Medical Center Directors agreed with our findings and recommendations. The implementation 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: Director, South Central VA Health Care Network (10N16)

SUBJECT: Healthcare Inspection – Post-Operative Paralysis, Overton Brooks VA Medical Center, Shreveport, Louisiana

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of an allegation regarding post-operative paralysis at the Overton Brooks VA Medical Center (the medical center), Shreveport, LA. A complainant alleged that an epidural catheter[1] caused a patient to be unable to move his lower extremities. The purpose of the review was to determine whether the allegation had merit.

Background

The medical center is a tertiary care hospital that is part of Veterans Integrated Service Network (VISN) 16. It provides a broad range of specialty services including surgical service. The medical center has six operating suites and performed 2,901 major surgical procedures during fiscal year 2010. The services of both anesthesiologists and certified registered nurse anesthetics are used in the provision of anesthesia care.

In August 2010, a confidential complainant contacted the OIG hotline with an allegation that a veteran received an epidural catheter for post-operative pain and that for 6 hours following surgery he was able to move his lower extremities; however, he later became paralyzed. The complainant believed that the paralysis was due to the epidural catheter.

In November 2010, the OIG hotline received several allegations from another confidential complainant regarding incidents that occurred in the medical center's operating room (OR). These allegations were not substantiated (see Appendix A).

[1] An epidural catheter is a small hollow tube that allows for the injection of an anesthetic drug into the space between the wall of the spinal canal and the covering of the spinal cord.

Scope and Methodology

Prior to our site visit, we interviewed the complainant by telephone. We conducted a site visit on November 17–19, 2010. We interviewed an anesthesiologist, thoracic surgeon, intensive care unit (ICU) nurse manager and staff nurses, risk manager, patient safety manager, and other clinical staff. We reviewed local and Veterans Health Administration (VHA) policies and procedures, the patient's medical record and ICU nursing flow sheets, published journals, quality management documents, patient incident reports, competency records, and the American Association of Critical Care Nurses standards of practice. We consulted with a board-certified anesthesiologist regarding insertion of the patient's epidural catheter.

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.

Case Summary

A patient in his seventies with chronic obstructive pulmonary disease was found to have an abnormal chest x-ray at the Alexandria VA Medical Center. Computed tomography[2] and positron emission tomography[3] scans (March and April 2010) revealed a suspicious nodule in his left lower lung. An early May, lung biopsy revealed poorly differentiated non-small cell carcinoma.

In early July (hospital day 1 HD1), the patient was admitted to the medical center for pre-operative evaluation. On HD2, a pulmonologist noted that the patient was at substantial risk for post-operative pulmonary complications. A cardiologist considered the patient to be at intermediate risk and recommended that volume overload (too much fluid in the blood) be avoided.

On HD4, the patient underwent left lower lung lobectomy.[4] Prior to surgery the patient had an epidural catheter placed for administration of medications to control post-operative pain.

At 3:30 p.m., the patient was transferred directly to the ICU for post anesthesia recovery in stable condition with an arterial line,[5] two chest tubes, an epidural catheter, oxygen, and two peripheral intravenous (IV) lines.

[2] Computed tomography is an x-ray procedure, which provides cross-sectional images.
[3] Positron emission tomography scans detect biochemical processes in the body that may indicate disease before the appearance of anatomical changes that other imaging studies may detect.
[4] A lung lobotomy is a surgery in which a lobe of the lung is removed.
[5] Arterial line is a thin catheter inserted into an artery to monitor the blood pressure in real time and to obtain samples for arterial blood gas measurement.

On arrival to the ICU, an initial assessment was completed and the patient's vital signs were reassessed every 15 minutes and neurological status every 30 minutes. The patient's blood pressure (BP) ranged from 98/40 to 128/53 millimeters of mercury. The patient was noted to be lethargic but was moving all four extremities. The post anesthesia period ended at 4:40 p.m. The patient's BP was 118/45 and no neurological deficits were noted.

At 7:00 p.m., a nurse noted on the ICU nursing flow sheet[6] that the patient began to develop hypotension. At that time, the patient's BP was 85/70. The nurse recorded the BP every 15 minutes. An hour later, the BPs ranged from 75/45 to 88/42. At 9:00 p.m., the nurse phoned the resident thoracic surgeon to report the patient's status. The nurse noted that verbal orders were received for blood tests (hemoglobin and hematocrit), a bolus[7] of Lactated Ringer's 1000 milliliters (ml) IV, and phenylephrine (drug used to treat hypotension) IV to maintain a mean arterial pressure (MAP)[8] greater than (>) 65. In order to maintain perfusion of major organs a MAP of 60 is necessary. The IV bolus was started, but the phenylephrine infusion was not initiated at this time.

At 9:35 p.m., the attending surgeon called the unit and verbal orders were given to the nurse to discontinue the fluid bolus and start a phenylephrine infusion. The nurse documented on the nursing flow sheet that the attending was in the ICU at 10:00 p.m. and that phenylephrine was infusing at that time. The patient's BP was 97/48 at 10:00 p.m. At 10:45 p.m. the BP was 105/52. At 11:00 p.m., the BP started to decline again; the BP was 87/47.

On HD5, at 12:00 a.m., the BP ranged from 69/37 to 76/40. At that time, the nurse wrote that the last three MAPs were less than (<) 60. The MAPs were not noted on the nursing flow sheet; however, the BPs were 78/43, 84/44, and 84/42. At 12:50 a.m., the nurse noted that the phenylephrine had been increased every 15 minutes without a significant change in the patient's BP. A resident was called at that time and orders were received to discontinue the phenylephrine and to start dopamine (drug used to increase the blood pressure), with the dose to be adjusted to maintain a MAP of at least 60, and to begin albumin IV.

At 1:00 a.m., phenylephrine was discontinued and a dopamine infusion was started. At 1:30 a.m., the patient's BP increased to 115/38. The patient's IV access in the left forearm was discontinued after the patient complained of pain when the IV access was flushed. The nursing staff was unable to restart the IV and notified the resident who discontinued the order for albumin. At 3:00 a.m., the nurse noted on the nursing flow sheet that the dopamine had been effective. The patient's BP was 99/41 at that time.

[6] The events from 7:00 p.m. on the day of surgery to 1:00 a.m., the following morning were documented on the ICU nursing flow sheet.
[7] Bolus is a large volume of fluid given intravenously and rapidly at one time.
[8] MAP is an average blood pressure in an individual.

At 6:45 a.m., during his assessment of the patient, an attending anesthesiologist documented that the patient was "completely unable to move his legs." The thoracic surgeons were immediately informed and the patient was discussed with a neurosurgeon.

The neurosurgeon consultant evaluated the patient at 8:16 a.m. and wrote:

> He [the patient] reports some sensory changes in his legs. I did not see any movements even with a painful stimulus. Reflexes were absent. There was no clonus.[9] There are several possibilities, including potential spinal cord infarction[10] and mass lesion. He was noted to be hypotensive in SICU and required two pressors to maintain his BP over night. A combination of thoracotomy and hypotension could definitely cause an infarction. An epidural catheter placement can cause a mass effect if there was a hematoma around the cord.

A magnetic resonance imaging (MRI) scan was obtained to determine if a hematoma was evident around the epidural catheter. The radiology report revealed, "Diagnostic consideration includes spinal cord infarction,[11] myelitis.[12] No evidence of paravertebral soft tissue hematoma seen." After the MRI, the epidural catheter was removed.

On HD6, the patient continued to report inability to move his legs, with sensation to touch and position sense on his feet, but no sensation to pain. The patient had slightly more sensation on his chest and abdomen and was feeling the chest wound, which he previously reported to be numb.

On HD7, the patient developed respiratory distress and subsequently was intubated and placed on a ventilator. The patient received a tracheostomy[13] on HD11.

On HD20, the patient was discharged to a non-VA long term acute care facility. At that time, the patient had some movement of the right leg but no movement of the left leg. The patient died 9 weeks later.

[9] Clonus is an abnormality in neuromuscular activity characterized by rapidly alternating muscular contraction and relaxation.
[10] Infarction is an area of tissue that undergoes necrosis (death) resulting from obstruction of the blood supply.
[11] Spinal cord infarction occurs when one of the three major arteries that supply blood (and therefore oxygen) to the spinal cord is blocked resulting in injury and destruction to the nerve fibers.
[12] Myelitis is inflammation of the spinal cord.
[13] Tracheostomy is a surgical procedure that creates an opening in the neck into the trachea (windpipe) to help get air to the lungs.

Inspection Results

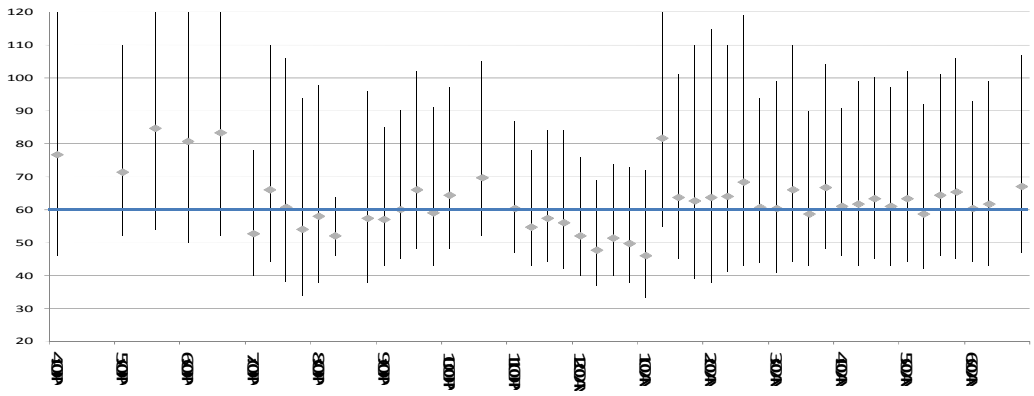
Issue 1: Quality of Post-Operative Care

We did not substantiate the allegation that an epidural catheter caused the patient's paralysis. We found no irregularities in the catheter's placement and the post-operative MRI revealed no findings suggestive of injury from the catheter.

The medical record shows that the patient was stable post procedure and transported directly to the ICU for post anesthesia recovery. The ICU Post Anesthesia Recovery note shows that the patient was moving all four extremities at 4:40 p.m. There was no documentation of the patient's neurological status again until 6:45 a.m. the next day when the anesthesiologist noted that the patient could not move his legs.

We reviewed the ICU nursing flow sheets and found that the patient was hypotensive in the ICU for a period of 6 hours. We reviewed the BPs documented by the nurse from 7:00 p.m. on the day of surgery to 1:00 a.m. the next morning. Although the order was to adjust the phenylephrine to the MAP, we found no documentation of MAPs on the nursing flow sheet. The nurse reported that MAPs were observed on the telemetry monitor and they were not required to document the MAP readings on the flow sheet. In order to determine the MAP during this time period, we calculated the MAPs using the standard formula.[14] We found 15 (65 percent) of the 23 MAPs were < 60. The BPs, to include MAPs, are displayed below in Figure 1.

Figure 1. Systolic, mean, and diastolic blood pressures, mm Hg



We determined that the ICU nurse was aware at 7:00 p.m. that the patient's BP was dropping, but did not call the resident until 9:00 p.m. The patient's MAP was continuously < 60 between 11:00 p.m. and 1 a.m., ranging from 46 to 57. The nurse did not inform the resident of the patient's condition until 12:50 a.m. Prior to notifying the resident, the nurse documented that the phenylephrine IV was adjusted every 15 minutes;

[14] MAP = [2 x diastolic + systolic] / 3 for example: 70/48 = (48x2+70)/3=55.3.

however, each titration was not documented. Therefore, the period of time the medication was adjusted, or how much of the medication the patient received could not be determined.

We also determined there was a delay in administering the phenylephrine. The nurse received a verbal order from the resident for the phenylephrine at 9:00 p.m. We did not find any documentation that the order was initiated. The nurse received another order for phenylephrine from the attending physician at 9:35 p.m. We could not determine when the medication was started, only that it was infusing at 10:30 p.m.

Issue 2: Nursing Documentation

We reviewed ICU nursing documentation and found that patient assessments were not completed according to local policy.[15] The policy requires that an initial assessment is completed on admission and reassessments every 2 hours or as needed based on patient's individual needs and change in level of care and diagnosis. The policy also requires an assessment to evaluate the response to care. We found that the ICU nurses completed the initial assessment and reassessments but they were incomplete. The assessments did not include documentation of the epidural catheter, neurological assessments, documentation of IV medications (phenylephrine), and the MAPs used as a measure to adjust the phenylephrine. The nurse manager acknowledged that documentation had been an ongoing problem and needed improvement.

Local policy[16] requires that telephone orders be accepted only in urgent circumstances and that the registered nurse enter verbal orders into the computerized patient record system (CPRS). The nurse received a verbal order for phenylephrine at 9:00 p.m. and a verbal order to discontinue the Lactated Ringer's IV bolus at 9:35 p.m. but did not enter the orders into CPRS.

Issue 3: Reporting of Adverse Events

Medical center managers did not conduct a review of the post-operative paralysis until after they were notified by OIG of the complainant's allegations. VHA requires[17] medical centers to conduct a review of certain adverse events for the purpose of quality improvement. Although the case was not reported at the time it occurred, managers took action once they were made aware of the incident. Managers determined that the patient's blood pressure dropped while in the ICU and was not treated as aggressively as it should have; however, it was not determined whether the low blood pressure was the cause of the patient's paralysis. The medical center later disclosed the event to the family.

[15] Policy 11-12, *Assessment and Care of Patients*, June 2008.
[16] Policy 119-01, *Physician Orders*, December 14, 2007.
[17] VHA Directive 2010-025, *Peer Review for Quality Management*, June 2010.

Conclusions

We did not substantiate that an epidural catheter insertion was the cause of the patient's paralysis. We found that the catheter insertion was performed according to standard procedures, and the radiology report did not reveal evidence of trauma from insertion of the catheter. However, we did find that prolonged hypotension may have contributed to spinal cord infarction and subsequent paralysis. We concluded that the patient's blood pressure was poorly monitored while he was in the ICU, and actions taken to treat his hypotension were inadequate. The medical center obtained peer review assessments of the care provided in the case described.

During our review, we identified two areas that needed improvement. First, ICU staff need to improve patient assessments and corresponding documentation. Second, senior leaders need to ensure that processes are in place for reporting and evaluating adverse events. Senior leaders were not informed of this incident until notified by OIG of the complaint; consequently, fact finding reviews were not initiated. Without appropriate reporting and evaluation of patient incidents, the medical center may miss opportunities to improve patient care and processes.

Recommendations

Recommendation 1. We recommended that the Medical Center Director ensure that patients in the ICU are assessed appropriately and that patient care activities are consistently documented.

Recommendation 2. We recommended that the Medical Center Director ensure that processes are in place for reporting and evaluating adverse events.

Comments

The VISN and Medical Center Directors concurred with our findings and recommendations (see Appendixes B and C, pages 9–15 for the full text of their comments). The implementation plans are acceptable, and we will follow up on the planned actions until they are completed.

(original signed by:)

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

Appendix A

Table 1. Alleged OR Incidents with OIG Findings and Conclusions.

Date	Allegation	Finding	Conclusion
August 31, 2009	A patient bled while on the OR table and later died.	We reviewed the medical record and found that the patient did not have surgery on August 31, 2009. In addition, the patient was still living.	Not substantiated
July 2010	A block was performed on the wrong extremity while four anesthesia staff members were present in the room.	We reviewed the operating room report and found that the surgical site was marked and timeout was performed to verify correct patient and site. We found no evidence that a block was performed on the wrong extremity.	Not substantiated
September 2010	A scrub technician was intoxicated in the OR.	We did not have enough information to pursue this allegation.	Neither confirmed nor refuted
September 14, 2010	The wrong local anesthetic was given to the surgeon to inject into the toe of a patient resulting in possible necrosis.	We reviewed the patient's medical record and did not find evidence of necrosis.	Not substantiated
November 17, 2010	Staff failed to perform a count after a microlaryngoscopy, resulting in the patient being x-rayed to determine if any surgical items were left in the patient.	We found that the procedure does not involve surgical items that could be left in the patient and that an x-ray is standard protocol after the procedure.	Not substantiated
Unknown	A physician was reported falling asleep during work hours, and was forced to have a sleep study.	We did not pursue the allegation because the medical center had taken appropriate action.	Neither confirmed nor refuted

Appendix B

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 26, 2011

From: Director, South Central VA Health Care Network (10N16)

Subject: **Healthcare Inspection – Post-Operative Paralysis, Overton Brooks VA Medical Center, Shreveport, Louisiana**

To: Director, San Diego Office of Healthcare Inspections (54SD)

Thru: Director, Management Review Service (10B5)

1. I have reviewed the report and concur with the recommendations and the stated action plans.

2. If you have any questions regarding the report, please contact Mary Jones, HSS [Health System Specialist] at (601) 206-6974.

(*original signed by*:)
George H. Gray, Jr., FACHE
Director, South Central VA Health Care Network (10N16)

Appendix C

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 22, 2011

From: Director, Overton Brooks VA Medical Center (667/00)

Subject: **Healthcare Inspection – Post-Operative Paralysis, Overton Brooks VA Medical Center, Shreveport, Louisiana**

To: Director, South Central VA Health Care Network (10N16)

1. I concur with the findings and recommendations of this Office of Inspector General report. The Overton Brooks VAMC appreciates the external perspective provided by this report. The Overton Brooks VAMC's reply outlines the actions taken in response to these findings. If there is any additional information required, you may contact Susan Lott, RN, Acting Chief, Performance Improvement Service at (318) 990-5125.

(*original signed by*:)
Kathleen Fogarty, FACHE
Director, Overton Brooks VA Medical Center (667/00)

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 Medical Center Director ensure that patients in the ICU are assessed appropriately and that patient care activities are consistently documented.

Concur **Target Completion Date:** December 30, 2011

Medical Center's Response:

As a result of this occurrence, the Overton Brooks VA Medical Center implemented a series of refresher courses or "Boot Camps" for nursing staff to improve the quality of care administered and to ensure that our veterans receive the appropriate care based upon their assessed needs. These educational boot camps cover various topics including: care of a patient with an epidural catheter; reemphasis of the basic expectations and guidelines of patient care in the ICU and step down units; mock code training; respiratory distress scenarios; cardiogenic shock scenarios; and a future course in hemodynamics. Full description and training dates are attached below. Additionally, the Overton Brooks VA Medical Center developed and implemented a new flow sheet which improves our documentation of the status of the patient and assists in ensuring compliance with local policies, VA National Policies, and The Joint Commission (TJC) standards.

The following actions have been taken to improve care in the ICU and Step Down units:

RCA Actions	Completed	Follow-up
1. Overton Brooks VA Medical Center implemented a new flow sheet for improved documentation of patient status and assist in ensuring compliance with local policies, VHA National Policies, and The Joint Commission (TJC) standards.	Completed document template and implemented March 24, 2011	Monthly record reviews to ensure staff utilization and accuracy. Report monthly to PI Committee and Nursing Leadership Committee.

2. All ICU staff completed an initial Post-Anesthesia Care Unit and surgical specialty specific competency and skills validation	Completed: March 30, 2011 24/26 =92.3% one nurse is deployed/one on extended leave	Follow up: Staff not completed will do so within 30 Days of return to duty.
3. Staff additionally read an article on the care of a patient with an epidural catheter and took a competency test based on the information given.	Completed: April 25, 2011 40/41= 97.6% One nurse deployed	Follow up: Staff not completed will do so within 30 Days of return to duty.
4. Staff are attending "Boot Camps" which will be provided in five (5) Sessions to reinforce competencies: The first "Boot camp" was in January 2011 and covered the guidelines, standards, and expectations for care of patients in the ICU. Including training on new ICU flow sheet	Completed: March 4, 2011 40/41= 97.6% One nurse is deployed	Follow up: Staff not completed will do so within 30 Days of return to duty.
5. The second "Boot camp" covered emergency situations which was in February 2011 and covered: • BLS [basic life support] • Use of Lifepack 20 for defibrillations, cardioversions and pacing • Location of supplies on crash cart • Autopulse • Technique for insertion of intraosseous needle	Completed: March 7, 2011 40/41= 97.6% One nurse is deployed	Follow up: Staff not completed will do so within 30 Days of return to duty.
6. The third "Boot Camp" covered respiratory distress which was in March 2011 and covered: • Ventilators- how to recognize and manage alarms • Use of IVAC • How to draw blood cultures • Use of restraints-proper alternatives and documentation Intubation setup/confirmation • Rapid sequence intubation testing • Care of patient on mechanical ventilator (alarms, troubleshooting, VAP bundle) • Continuous sedation while on ventilator (demonstrated setup on IV	Completed: March 30, 2011 39/41=95.1% One nurses is deployed and one on extended leave	Follow up: Staff not completed will do so within 30 Days of return to duty.

pump and score pain using nonverbal pain scale) • Monitoring and documentation of level of sedation using RASS scale • Central line setup for insertion • Chest tube setup and care (in scenario patient develops pneumothorax after central line insertion) • Maintenance of chest tubes • Completed and passed test on rapid sequence intubation and ventilators.		
7. The fourth "Boot Camp" will be held the end of April 2011 and will cover IABP's. By the end of this session the staff will have taken an online class and completed an associated test. Additionally, they will receive hands on training from our IABP vendor representative.	Completed Date: Boot Camp will be held April 26 – April 27	Pending Completion
8. The final "Boot Camp" will be held in May and will focus on: • Hemodynamics. • This session will cover Femstop, Port-a-Cath, Alaris Pumps and set up for PCA, • Med Sled, • Heparin protocol, and • Competency Test covering hemodynamics and Duotube.	Boot Camp will be held in May 2011	Pending Completion
9. Nursing Leadership will ensure a comprehensive test be administered to the attendees to ensure understanding of the information or training provided.	Pending Completion	
10. Future Boot Camp plans are being finalized. The plan is for the majority of the information to be incorporated into new ICU and Step Down nurse employee orientation, with additional classes being held throughout the year on low volume high impact topics.	Pending Completion	

Recommendation 2. We recommended that the Medical Center Director ensure that processes are in place for reporting and evaluating adverse events.

Concur **Target Completion Date:** December 30, 2011

Medical Center's Response:

Upon discovery of this event, a Root Cause Analysis (RCA) Team was chartered. The charter for this RCA was to review events related to this occurrence regarding the reporting aspects, and to determine methods by which to increase requirements for and awareness of reporting of adverse events. The following were actions taken by the medical center as a result of the RCA:

RCA Actions	Completed	Follow-up
Revise Patient Safety Program policy to require all who witness an adverse event to report the event to Patient Safety/ ensure that the event is reported to Patient Safety.	January 5, 2011	Completed
Revision of Attachment C of Patient Safety Program, "Incident Occurrences" to include a simplified algorithm outlining reporting/notification process.	January 5, 2011	Review a 20% sample of all incident reports for April, May, and June 2011 to ensure proper notification processes followed – Due July 2011
Posting of simplified Algorithm in clinical areas.	April 2, 2011	Random survey of staff regarding knowledge of algorithm – Due August 2011
A direct link to the incident report form with inclusion of Patient Safety Reporting Hotline phone number added the Medical Center Intranet homepage.	January 31, 2011	Review the number of times direct link accessed for April, May, and June 2011 to determine efficacy – Due July 2011
Education of all staff regarding what incidents/adverse events are, requirement for reporting of events and close calls, how to report events and close calls, use of algorithm and use of direct link.	MCD staff– February 28, 2011 COS staff– February 3, 2011 Acting Associate Director staff– March 30, 2011 Acting Nurse Executive staff– April 14, 2011	Patient Safety Manager to review for percentage increase in incident reporting throughout fiscal year 2011
All ICU nursing staff and nurse mangers have been educated on where the incident form (VAF10:2633) is located and how to use them appropriately.	Completed: April 1, 2011 40/41= 97.6% One nurse is deployed	Staff not completed will do so within 30 days of return to duty
On March 9, 2011, OR staff participated in a one day "Safety Stand Down." The OR staff reviewed proper safety procedures and what could happen if these procedures are not followed correctly. The Stand Down was conducted by the VISN CMO and VISN Lead Surgeon.	Sixteen OR Staff participated, while the other staff where still doing their cases. The information was shared and all were made aware of the situation and the material covered.	

Appendix D

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	Deborah Howard, RN, Project Leader Stephanie Hills, RN, Team Leader Sheila Bezak, RN Elizabeth Burns, MSSW Jerome Herbers, MD Sandy Khan, RN Derrick Hudson

Appendix E

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, South Central VA Health Care Network (10N16)
Director, Overton Brooks VA Medical Center (667/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Mary L. Landrieu and David Vitter
U.S. House of Representative: Rodney Alexander, Charles W. Boustany, Jr., William "Bill" Cassidy, John Fleming, Jeffrey Landry, Cedric Richmond and Steve Scalise

This report is available at http://www.va.gov/oig/publications/reports-list.asp.