Administrative Closure
Patient Safety Issues
West Palm Beach VA Medical Center (548)
West Palm Beach, Florida
MCI# 2013-03948-HI-0473

The VA Office of Inspector General, Office Healthcare Inspections, Bay Pines, was informed of concerns by the West Palm Beach OIG Office of Criminal Investigations that a patient became disconnected from a ventilator and had a subsequent cardiac arrest at the West Palm VA Medical Center, West Palm Beach, FL (facility). It was conveyed to us by the investigator that while no criminal issues were identified, health care questions remained unanswered. The purpose of our review was to determine if substandard safety issues at the facility contributed to the patient's cardiac arrest that required resuscitations. We specifically addressed if:

- There was a failure to ensure the patient had safe ventilator equipment.
- The nursing staff was competent to care for a patient on a ventilator.
- The patient was monitored appropriately.
- The patient had adequate mental health care during the hospitalization.

Case Summary

The patient was a (b)(6) male with diagnoses of progressive amyotrophic lateral sclerosis, bipolar disorder, and (b)(3):38 U.S.C. 7332. He has been ventilator dependent since (b)(6) 2012, and had a permanent tracheostomy. The patient was receiving home based primary care and having behavioral problems and conflict with his wife.

On (b)(6), the psychiatrist recommended admission to the community living center for respite care. The patient and the wife were in agreement with this plan. The mental status exam for this date noted that the patient was not delusional, hallucinating, homicidal, or suicidal.

On (b)(6), the wife brought the patient to the emergency department claiming that he was threating suicide, agitated, and physically aggressive with his wheelchair. The patient was admitted under the Baker Act (mandatory 72 hour stay). A medical evaluation indicated there were no acute medical problems. Since no beds were available in the long term ventilator care unit, the patient was admitted to a medical unit with a 1:1 sitter, full code status, and a psychiatric consult was requested. The patient was allowed to use his own ventilator despite documentation from Home Based Primary Care that the patient's family persisted in deactivating the ventilator alarms.

On (b)(6), a rapid response team was activated to treat the patient's respiratory distress and low oxygen levels. A physician recommended transfer to the intensive care unit after the patient was stabilized, but the patient refused. On (b)(6), Respiratory Therapy Services was called to suction the patient and noted that the patient was disconnected from the ventilator, unresponsive, and had no pulse. The patient was resuscitated, transferred to intensive care, and placed on a facility ventilator.

On (b)(6) the patient was discharged to home with specific home health instructions for settings of his home ventilator, alarm functions, tracheostomy care. gastric tube feedings, and aspiration precautions.

We contacted the facility, requested all relevant documents regarding the adverse events. We reviewed a Root Cause Analysis report of the event, fact finding conclusions, a VISN issue brief, peer reviews, cardiac arrest review, reports of contact, incident reports, facility policies, and all documentation of facility leadership actions taken in response to the event. We also completed a review of the patient's electronic health record.

Inspection Results

We determined that the facility's equipment management plan did not address whether or not home life support equipment could be used in the hospital, or require biomedical inspections of life support equipment brought into the hospital to assess outside/ personal medical equipment for safe operation and clinical alarm functions.

We determined that placing the patient on a medical unit where staff were not competent in ventilator care was not appropriate. We also determined that it was inappropriate to allow the patient to use his own ventilator and insist that his ventilator alarms remain off and the settings locked. The adverse events affecting the patient could have been avoided if appropriate patient safety measures had been taken upon admission; and the nursing, physician, and/or respiratory therapy staff had reported their concerns to managers before the patient became compromised.

We determined it was also inappropriate to allow the patient to refuse intensive care treatment following his respiratory distress episode without determining patient's capacity to refuse treatment in light of a hypoxic event and previous preference for full code status. .

We also found the mental health care was inadequate. Mental health providers did not follow the patient closely despite the fact he was admitted for mental health issues.

Facility Response

We were provided information and documentation that the facility took aggressive measures to correct the identified patient safety, policy, and competency deficiencies. Actions taken included: patients will only be admitted to an appropriate unit with competent staff, use of home ventilators will not be allowed, and the equipment management policy was updated. Peer reviews were completed for physician and nursing staff. Psychiatry Services was directed to see all inpatients on a regular basis, and Nursing and Respiratory Therapy Services were educated regarding reporting of unsafe patient conditions.

Since the facility initiated aggressive and appropriate actions, we recommended administrative closure.

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