Administrative Closure
Alleged Safety Issues in the Surgical Intensive Care Unit
New Mexico VA Healthcare System Albuquerque, NM
MCI # 2012-02149-HI-0373

On March 21, 2012, the Office of Inspector General Office of Healthcare Inspections received allegations submitted by two [redacted] regarding a Continuous Veno-Venous Hemodialysis[1] (CVVHD) performed on a patient in the SICU at the New Mexico VA Health Care System (the facility), Albuquerque, NM.

The complainants alleged that when CVVHD was performed for the first time at the facility, there were no CVVHD policies/procedures in place, the staff were not trained or credentialed to provide CVVHD care, there were not enough staff on duty to provide the care, and there was no oversight or consultation by nephrology.

On March 22, 2012, an OHI Denver Regional Office inspector spoke with the facility Director who was aware of the circumstances surrounding the CVVHD and the allegations in the complaint. The Director reported that a physician who was trained in CVVHD, performed the procedure from March 14, at 9:30 p.m. until March 16, at 6:00 a.m. The veteran had a good outcome and was eventually discharged to home.

When the Director became aware of the CVVHD issues, he requested that Biomedical Engineering remove all the CVVHD equipment and launched a new planning and implementation team to address multidisciplinary needs for a safe CVVHD program. A contingency plan for emergency CVVHD was developed and communicated to key staff.

At the request of the VISN 18 Network Director, the Chief Medical Officer and Quality Management Officer conducted a fact-finding review on April 2-5, 2012. The review recommendations include that the facility Director:

1. Institute a comprehensive, interdisciplinary planning process for CVVHD, and establish a standard process for the introduction of new services in the future, including a final facility-level approval process that addresses appropriateness, resources, staffing, and training.
2. Ensures the Executive Committee of the Medical Staff approves new clinical care modalities prior to implementation.

[1] CVVHD is a type of continuous dialysis, generally considered only for critical hemodynamic instability with renal failure. Research shows that CVVHD can improve hemodynamic and cerebrovascular stability. However, clinical research studies are limited.

3. Ensures that clinical privileges are granted prior to initiating new clinical care modalities.
4. Establishes a process to thoroughly review facility equipment prior to purchase, including associated programmatic requirements.
5. Ensures that written procedures and protocols are developed and approved by appropriate staff prior to implementation of new clinical care modalities.
6. Ensures that all appropriate staff are trained and determined to be fully competent prior to providing new services.
7. Develops and implements a strategy to improve interdisciplinary communication and collaboration, including the establishment of clear expectations about communication of issues to, from, and within Medical Staff leadership.

The VISN Quality Management Officer will track the recommendations monthly until completed. The Director requested an outside peer review of this case to determine if care for this veteran was appropriate.

We found that the hotline allegations are being appropriately addressed by the facility. and that corrective action plans are in plaee to ensure that a safe CVVHD program is developed.

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