



THE SECRETARY OF VETERANS AFFAIRS

WASHINGTON

December 9, 1999

The Honorable Elaine Kaplan  
U.S. Office of Special Counsel  
1730 M Street, N.W., Suite 300  
Washington, DC 20036-4505

Re: OSC File No. DI-99-0748

Dear Ms. Kaplan:

This is in further response to your August 4, 1999, letter regarding allegations by a physician anesthesiologist against a nurse anesthetist at the Carl T. Hayden Department of Veterans Affairs Medical Center (VAMC), Phoenix, AZ. VA's Office of the Medical Inspector (OMI) has completed its review of these allegations. I accept the findings in this report and will ask the Veterans Health Administration (VHA) to take additional action in some areas. Details are included in Enclosure 1.

The Medical Inspector's office will continue to oversee the anesthesia situation at the Phoenix VAMC and report its findings on a periodic basis to the Acting Under Secretary for Health and to my office. Enclosed are two copies of the report; one is redacted.

Please have a member of your staff contact Dr. James E. McManus, the Medical Inspector, if you have any questions or comments. He can be reached at 202-273-8940.

Sincerely,

A handwritten signature in black ink that reads "Togo D. West, Jr." with a large, stylized flourish extending from the end of the signature.

Togo D. West, Jr.

Enclosures (3)

**The Department of Veterans Affairs (VA) Investigation Results  
VA Medical Center Phoenix, AZ – Nurse Anesthetist**

The OMI's report has addressed the requirements of 5 U.S.C. § 1213(d) as follows:

**1. A summary of the information with respect to which the investigation was initiated:**

The Medical Inspector responded to an inquiry from the United States Office of Special Counsel (OSC) to the Secretary of Veterans Affairs, dated August 4, 1999, regarding allegations against a nurse anesthetist made by an anesthesiologist (complainant) at the Carl T. Hayden VA Medical Center, Phoenix, AZ (the Medical Center). The anesthesiologist claimed that the nurse anesthetist's "negligent behavior has caused at least four patient deaths, and has resulted in the collapse of at least another eight patients after surgery." Information provided to OSC by the anesthesiologist was considered to demonstrate "a substantial likelihood that a substantial and specific danger to public health and safety exists at the Medical Center."

**2. A description of the conduct of the investigation:**

- a) A site visit to the Medical Center in September 1999 was conducted by two staff members from the Office of the Medical Inspector (OMI) and three surgery and anesthesia consultants who are nationally recognized for their clinical expertise.
- b) Medical records of 14 patients were reviewed, 12 of which were listed by the anesthesiologist in information he provided to the OSC. Two additional medical records were reviewed on site.
- c) Interviews were conducted with senior management staff, the Acting Chief of Surgery, the Acting Chief of Anesthesia, nurse managers, operating room nurses, nurse anesthetists, post-anesthesia care unit (PACU) nurses, quality management staff, a staff anesthesiologist, the complainant and his attorney, and the subject nurse anesthetist.
- d) Quality improvement documents and minutes of Anesthesia Mortality and Morbidity Conferences were reviewed.
- e) Personnel folders of the nurse anesthetists were reviewed to determine dates of their last proficiency ratings.

**3. A summary of any evidence obtained from the investigation:**

- a) Sub-standard anesthesia care was provided in six of 14 cases<sup>1</sup> in which the subject nurse anesthetist participated over a period extending from 1993 to 1999. Although not solely responsible for this substandard care, interviews

<sup>1</sup> The complainant cited twelve of the 14 cases; an additional two were identified during the site visit.

with PACU staff members indicated that this nurse anesthetist had anesthesia care incidents in the PACU in numbers greater than the other five nurse anesthetists.<sup>2</sup>

- b) Premature endotracheal extubation at the end of anesthesia appeared to be the primary problem in six patients. Criteria for endotracheal extubation at the end of anesthesia were not in place at the Medical Center during this period.
- c) Staff indicated that the nurse anesthetist in question was at times brusque, intimidating, moody, bullying and volatile. Also, it was reported that the subject nurse anesthetist was heard to speak about some veteran patients in a deprecating, insulting manner.
- d) The Medical Center lacked a plan and a process to measure and assess data regarding anesthesia quality issues during the period from 1993 to March 1999. The former Chief of the Anesthesia Section performed reviews, but on a case-by-case basis. There were no documented Anesthesia Mortality & Morbidity (M & M) Conferences before March 1999.
- e) Actions by the former Chief of the Anesthesia Section (and by the former Chief of Surgery) regarding anesthesia quality of care issues were ineffectual or absent. Nursing staff told OMI team members that they reported post-anesthesia quality of care issues to their superiors. However, no actions were taken. The Chief of Staff indicated that he was unaware of problems in the Anesthesia Section until the time of the initial site visit by the OMI in March 1999.
- f) There were significant reductions in anesthesia-related incidents in the six-month period from March to September 1999. For example, there were no reintubations in the PACU for the three months of June, July and August 1999.

**4. A listing of any violation or apparent violation of law, rule or regulation:**

Failure to provide a proficiency rating for the subject nurse anesthetist since January 1997 violates policy and procedural requirements authorized by 38 U.S.C. 501 (a), 7421, and set forth in VA's MP-5, Part II, Chapter 6, entitled Proficiency Rating System, dated October 30, 1998.

**5. A description of any action taken or planned as a result of the investigation, such as:**

**a) changes in agency rules, regulations or practices;**

The OMI is evaluating the need to recommend that standardized extubation guidelines at the termination of anesthesia be applied throughout Veterans Health Administration facilities. The Acting Under Secretary for Health will assure that appropriate guidelines are in place at the facility and that the OMI and VA's Office of Patient Care Services expeditiously provide recommendations regarding national guidelines.

**b) the restoration of any aggrieved employee;**

<sup>2</sup> Six nurse anesthetists administered approximately 95% of the anesthesia at the Medical Center.

Not applicable

**c) against any employee;**

Continued close supervision and monitoring of the nurse anesthetist is recommended. Also, VHA will instruct the facility, through Veterans Integrated Service Network 18, to assure that appropriate action is taken with respect to both the nurse anesthetist's performance and his interpersonal behavior.

**d) referral to the Attorney General of any evidence of a criminal violation.**

Not applicable

**6. Management initiatives related to this review include the following:**

- a) Regular Anesthesia M & M Conferences began in March 1999. The minutes of the conferences contain reviews of anesthesia quality of care issues with recommendations and actions.
- b) Effective supervision and monitoring of the subject nurse anesthetist by the new Acting Chief of the Anesthesia Section began in March 1999, and is continuing.
- c) Guidelines for endotracheal extubation have been developed by Anesthesia staff members at the Medical Center.
- d) Systematic data collection on specific anesthesia care performance measures (indicators) was begun in June 1999.

**7. Conclusion:**

The Medical Inspector concludes that the *allegation* that the nurse anesthetist's "negligent behavior has caused at least four patient deaths, and has resulted in the collapse of at least another eight patients after surgery" is incorrect. The nurse anesthetist participated in the anesthesia in only six of the 14 cases reviewed by the Office of the Medical Inspector in which there was a question concerning the quality of anesthesia care. Of the 14 patients, three died. Based on the review of medical records, interviews with clinical and management staff, the review of personnel folders and quality improvement documents, the Medical Inspector found no evidence that the nurse anesthetist's behavior caused the three patient deaths. The nurse anesthetist was not solely responsible for the substandard care provided in any of the six instances identified during the OMI investigation.

**Office of the Medical Inspector**

**Special Report to:  
U.S. Office of Special Counsel**

**Veterans Integrated Service Network 18  
Carl T. Hayden VA Medical Center  
Phoenix, AZ**

**Review of Allegations Regarding  
Anesthesia Care**

**Prepared by:**

The Office of the Medical Inspector (10MI)  
Veterans Health Administration  
Department of Veterans Affairs  
810 Vermont Avenue, NW  
Washington, DC 20420



Department of  
Veterans Affairs

**Report Date: December 9, 1999**

**Privacy Act**

This report contains information subject to the provisions of the Privacy Act of 1974 (5 U.S.C. 552a). Such information may be disclosed only as authorized by this statute. Questions regarding the release of this report or any part thereof should be coordinated with the Veterans Health Administration. The contents of this report must be safeguarded from unauthorized disclosure.

**Carl T. Hayden VA Medical Center  
Phoenix, AZ  
Veterans Integrated Service Network (VISN) 18**

**Executive Summary**

The Executive Summary is presented as specified in the reporting requirements of 5 U.S.C., Section 1213d.

**1. A summary of the information with respect to which the investigation was initiated:**

The Medical Inspector responded to an inquiry from the United States Office of Special Counsel (OSC) to the Secretary of Veterans Affairs, dated August 4, 1999, regarding allegations against a nurse anesthetist made by an anesthesiologist (complainant) at the Carl T. Hayden VA Medical Center, Phoenix, AZ (the Medical Center). The anesthesiologist claimed that the nurse anesthetist's "negligent behavior has caused at least 4 patient deaths, and has resulted in the collapse of at least another 8 patients after surgery." Information provided to OSC by the anesthesiologist was considered to demonstrate "a substantial likelihood that a substantial and specific danger to public health and safety exists at the Medical Center."

**2. A description of the conduct of the investigation:**

- a) A site visit to the Medical Center in September 1999 was conducted by two staff members from the Office of the Medical Inspector (OMI) and three surgery and anesthesia consultants who are nationally recognized for their clinical expertise.
- b) Medical records of 14 patients were reviewed, 12 of which were listed by the anesthesiologist in information he provided to the OSC. Two additional medical records were reviewed on site.
- c) Interviews were conducted with senior management staff, the Acting Chief of Surgery, the Acting Chief of Anesthesia, nurse managers, operating room nurses, nurse anesthetists, post-anesthesia care unit (PACU) nurses, quality management staff, a staff anesthesiologist, the complainant and his attorney, and the subject nurse anesthetist.
- d) Quality improvement documents and minutes of Anesthesia Mortality and Morbidity Conferences were reviewed.
- e) Personnel Folders of the nurse anesthetists were reviewed to determine dates of their last proficiency ratings.

**3. A summary of any evidence obtained from the investigation:**

- a) Sub-standard anesthesia care was provided in six of 14 cases<sup>1</sup> in which the subject nurse anesthetist participated over a period extending from 1993 to 1999. Although not solely responsible for this substandard care, interviews with PACU staff members confirmed that he had anesthesia care incidents in the PACU in numbers greater than the other five nurse anesthetists.<sup>2</sup>
- b) Premature endotracheal extubation at the end of anesthesia appeared to be the primary problem in six patients. Criteria for endotracheal extubation at the end of anesthesia were not in place at the Medical Center during this period.
- c) Staff confirmed that the nurse anesthetist in question had behavioral issues, and was at times brusque, intimidating, moody, bullying and volatile. Also, the subject nurse anesthetist was heard to speak about some veteran patients in a deprecating, insulting manner.
- d) The Medical Center lacked a plan and a process to measure and assess data regarding anesthesia quality issues during the period from 1993-1999. The former Chief of the Anesthesia Section performed reviews, but on a case-by-case basis. There were no documented Anesthesia Mortality & Morbidity (M & M) Conferences before March 1999.
- e) Actions by the former Chief of the Anesthesia Section (and by the former Chief of Surgery) regarding anesthesia quality of care issues were ineffectual or absent. Nursing staff told OMI team members that they reported post-anesthesia quality of care issues to their superiors. However, no actions were taken. The Chief of Staff claimed that he was unaware of problems in the Anesthesia Section until the time of the initial site visit by the OMI in March 1999.
- f) There were significant reductions in anesthesia-related incidents in the six-month period from March to September 1999. For example, there were no re-intubations in the PACU for the three months of June, July and August 1999.

**4. A listing of any violation or apparent violation of law, rule or regulation:**

Failure to provide a proficiency rating for the subject nurse anesthetist since January 1997 violates policy and procedural requirements authorized by 38 U.S.C. 501 (a), 7421, and set forth in VA's MP-5, Part II, Chapter 6, entitled Proficiency Rating System, dated October 30, 1998.

**5. A description of any action taken or planned as a result of the investigation, such as:**

**a) changes in agency rules, regulations or practices;**

The OMI is evaluating the need to recommend that standardized extubation guidelines at the termination of anesthesia be applied throughout Veterans Health Administration facilities.

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<sup>1</sup> The complainant cited twelve of the 14 cases; an additional two were identified during the site visit.

<sup>2</sup> Six nurse anesthetists administered approximately 95% of the anesthesia at the Medical Center.

**b) the restoration of any aggrieved employee;**

Not applicable

**c) against any employee;**

Continued close supervision and monitoring of the nurse anesthetist is recommended.

**d) referral to the Attorney General of any evidence of a criminal violation.**

Not applicable

**6. Management initiatives related to this review include the following:**

- a) The Medical Center accepted the resignation of the former Chief of Anesthesia on February 27, 1999.
- b) A contract for anesthesia services was established immediately. The new Acting Chief of Anesthesia began in March 1, 1999.
- c) Regular Anesthesia M & M Conferences began in March 1999. The minutes of the conferences contain reviews of anesthesia quality of care issues with recommendations and actions.
- d) Effective supervision and monitoring of the subject nurse anesthetist by the new Acting Chief of the Anesthesia Section began in March 1999, and is continuing.
- e) Criteria for endotracheal extubation were being developed by Anesthesia staff members at the Medical Center in September 1999.
- f) Systematic data collection on specific anesthesia care performance measures (indicators) was begun in June 1999.

**7. OMI Conclusion:**

The Medical Inspector concludes that the allegation that the nurse anesthetist's "*negligent behavior has caused at least four patient deaths, and has resulted in the collapse of at least another eight patients after surgery*" is incorrect. The nurse anesthetist participated in the anesthesia in six of the 14 cases reviewed by the Office of the Medical Inspector in which there was a question concerning the quality of anesthesia care. Of the 14 patients, three died. Based on the review of medical records, interviews with clinical and management staff, the review of personnel folders and quality improvement documents, the Medical Inspector found no evidence that the nurse anesthetist's "*negligent behavior caused*" the three patient deaths. The nurse anesthetist was not solely responsible for the substandard care provided in any of the six instances identified during the investigation.

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## **I. Introduction**

The OMI responded to an inquiry from the Office of Special Counsel (OSC) to the Secretary of Veterans Affairs dated August 4, 1999, regarding allegations against a nurse anesthetist from a former anesthesiologist, at the Carl T. Hayden VA Medical Center, Phoenix, AZ (hereafter, the Medical Center). Three surgery and anesthesia expert consultants and two OMI members conducted a site visit on September 20-23, 1999.

In his communication with the OSC, the former staff anesthesiologist provided information that "demonstrates a substantial likelihood that a substantial and specific danger to public health and safety exists" at the Medical Center. The anesthesiologist claimed that the nurse anesthetist's "negligent behavior has caused at least 4 patient deaths, and has resulted in the collapse of at least another 8 patients after surgery."

## **II. Methodology**

The five-person OMI team reviewed the medical records of 12 patients cited in the complaint from the OSC. Two additional medical records were reviewed on-site. The OMI team conducted 23 interviews with senior management; Chiefs of Surgery and Anesthesia; nurse managers; operating room staff; anesthesia staff members (6 nurse anesthetists and 4 anesthesiologists); the complainant and his attorney; post-anesthesia care unit (PACU) nursing staff members and the nurse anesthetist in question. They also reviewed minutes of the Anesthesia Morbidity and Mortality Conferences (M & M Conferences) and recent quality improvement documents. Personnel Folders of the nurse anesthetists were reviewed to determine dates of their last proficiency ratings.

## **III. Background**

On March 10-11, 1999, the OMI conducted its first site visit to the Medical Center to address surgery and anesthesia issues. In the months of April, June and July 1999 the OMI conducted three additional site visits: 1) to review the overall quality of care at the Medical Center, 2) to analyze mortality and morbidity rates at the Medical Center, 3) to conduct Peer Reviews of selected cases, and 4) to perform patient and staff satisfaction surveys. Reports covering the above aspects of the investigation are in preparation. The draft report of the initial visit in March 1999 was issued in August 1999.

## **IV. Relevant Findings of the March 1999 OMI Site Visit**

The OMI team's relevant on-site findings in March 1999 were as follows:

- The Medical Center's Chief of Staff and other top management were unaware of many of the problem issues related to anesthesia and surgery. The former Chief of

Surgery, the Acting Chief of Surgery and the former Chief of Anesthesia did not communicate these serious concerns upwards.

- The Surgical M & M Conferences where anesthesia and surgical complications and deaths were discussed were closed to nurse anesthetists, registered nurses in the PACU, the surgical intensive care unit (SICU) and other clinical areas, and quality improvement staff. Anesthesia M & M Conferences were started in March 1999. Physician anesthesiologists and nurse anesthetists attend the meetings.
- Medical Center anesthesia and surgical staff did not review the quality of preoperative surgical and anesthesia risk assessments. Significant clinical findings, such as, abnormal pulmonary, cardiac or hematological conditions, were not adequately addressed.
- Anesthesia staff did not monitor Quarterly Surgical Reports and the observed to expected morbidity and mortality ratios to determine if anesthesia issues, for instance, re-intubation, contributed to the morbidity and mortality of surgical patients.
- The Anesthesia Section did not benefit from being a Section of the Surgical Service in terms of staffing, equipment and the assessment and improvement of quality in anesthesia care.
- Medical Center management did not conduct and document a review of the adequacy of the infrastructure supporting the surgical and anesthesia programs.
- Surgical and anesthesia leaders supported a peri-operative anesthesia and surgery function that had built-in communication gaps among surgeons and anesthetists, and among nurse anesthetists and physician anesthesiologists. The existing peri-operative function was fragmented and lacked continuity. From the beginning of the process in the Surgical Clinic, through the pre-operative surgical and anesthesia assessment, the intra-operative procedure and administration of anesthesia phase, and to the post-anesthesia care period, several areas for improved communication and coordination of information were identified.
- PACU nursing staff members were concerned about the adequacy reversal from anesthesia and the safe transport of patients from the operating suite to the PACU and/or SICU. This included transporting patients from the operating room suite (OR) without oxygen. There were inadequate verbal and written reports of the status of patients. The hand-off of patients from one care setting (OR) to the next setting during this phase of post-anesthesia care was problematic. Appropriate monitors to measure carbon dioxide levels and additional physiological parameters in transporting patients from the operating suite and from PACU were not in place at the time of the March 1999 OMI visit.

- There was inadequate administrative support for physician and nurse managers. This included the minimal administrative support provided to the former Chiefs of Surgery and Anesthesia.

#### **V. Actions Taken by the Medical Center – March 1999 to September 1999**

- The Medical Center accepted the resignation of the former Chief of Anesthesia on February 27, 1999.
- A contract for anesthesia services was established immediately. The new Acting Chief of Anesthesia began in March 1, 1999.
- Minutes of the Anesthesia M & M Conferences contained documented reviews of current quality of care issues with recommendations and actions.
- Quality improvement documents; interviews with the subject nurse anesthetist and other nurse anesthetists; interviews with PACU staff members; and an interview with the Acting Chief of the Anesthesia Section indicate that there has been a significant reduction in anesthesia-related quality of care issues in the past six months.
- Effective supervision and mentoring sessions between the new Acting Chief of Anesthesia and the subject nurse anesthetist were begun in March 1999. Beginning in March 1999 the new Acting Chief of Anesthesia monitored the subject nurse anesthetist's anesthesia care towards the end of each anesthesia.
- Systematic data collection was begun in June 1999 regarding several anesthesia performance measures.

#### **VI. OMI Review of the 14 Medical Records**

OMI team members reviewed the medical records of each patient identified by the complainant as having received substandard anesthesia care and found two additional records on-site. The review consisted of:

- A. A verbatim allegation by the complainant;
- B. An abstract of relevant clinical information based on medical record review;
- C. OMI findings; and
- D. OMI conclusions represented by assignment of a ranking score.

The scoring system of peer review used by the team consisted of three levels:

- Level 1: Most practitioners would have given anesthesia care the same way.
- Level 2: Some practitioners would have given anesthesia care differently.
- Level 3: Most practitioners would have given anesthesia care differently.

## 1. Medical Record

### A. Allegation:

*“Triple Scope. Collapsed in the Recovery Room. Turned blue; required re-intubation.”*

### B. Abstract of Medical Record:

This [REDACTED] patient was admitted on [REDACTED] for panendoscopy with biopsy. He had a history of one month’s duration of hoarseness and dysphagia and had myocardial infarctions in 1988 and 1990. Physical findings included bilateral expiratory wheezes and a patchy white lesion on the left tonsil. The procedure was performed on [REDACTED]. A diagnosis of tonsillar carcinoma was confirmed. The surgeon’s note indicates the patient tolerated the procedure well. He was extubated in the operating room. He was awake and had adequate respirations. Documentation in the PACU shows an uneventful course. Oxygen saturation ranged from 98-100%. He was transferred to the general inpatient unit. A nursing note at 3:30 p.m. indicated that the patient was tolerating fluids well. He was discharged from the Medical Center the following day.

### C. Findings:

There was no evidence to support the allegations of the complainant. The anesthesia care provided to this patient was appropriate.

### D. Conclusion:

A Level 1 was assigned to this case.

## 2. Medical Record

### A. Allegation: *“Hernia repair. Collapsed. Went to Surgical Intensive Care Unit.”*

### B. Abstract of Medical Record:

This [REDACTED] patient underwent a bilateral direct inguinal hernia repair on [REDACTED]. He had chronic obstructive pulmonary disease (COPD), ankylosing spondylitis, and a history of difficult oral intubation. The general anesthesia lasted three hours. The

patient was extubated in the operating room by the subject nurse anesthetist and transported to the post-anesthesia care unit (PACU). A PACU nursing note indicated that the patient was awake on arrival, but "had poor muscular response." A second dose of "reversal drugs" was given. He developed respiratory distress and required reintubation 35 minutes after extubation. A post-anesthesia note stated that the respiratory failure was most likely caused by a combination of restrictive and obstructive ventilation deficits. Three anesthesiologists, including the supervising physician at the time, attended the patient during this clinical event. He was finally extubated on the fifth post-operative day in the surgical intensive care unit (SICU).

C. Findings:

The criteria used for extubation were not charted on the anesthesia record. That the patient was extubated prematurely is probable, given his history of COPD and spondylitis with kyphosis that likely limited effective expansion of the lungs. Reversal from anesthesia was inadequate, given the need to administer a second dose of reversal drugs 15 minutes after the patient's arrival in PACU.

D. Conclusions:

Three of the four OMI reviewers assigned a Level 3 to this case. A Level 2 was assigned by one reviewer on the basis that the early extubation could be considered "a reasonable trial of extubation, which, if successful, would then have obviated the need for prolonged endotracheal intubation and its attendant risks."

### 3. Medical Record

A. Allegation: *"Turned cyanotic in Recovery Room. Required reintubation."*

B. Abstract of Medical Record:

This patient, a [REDACTED] man, presented to Ambulatory Surgery on [REDACTED] [REDACTED]. The surgeon of record administered local anesthesia with Lidocaine 1% with Epinephrine. Two sebaceous cysts were removed from his posterior neck without complication.

C. Findings:

Documentation reflects that excellent care was provided to the patient during this minor surgical procedure. The subject nurse anesthetist did not participate in his care.

D. Conclusion:

Information in this record does not match the complainant's allegation.

5 U.S.C. §  
552(b)(6)

#### 4. Medical Record

A. Allegation: *"Total Hip Surgery. Collapsed. To SICU."*

B. Abstract of Medical Record:

This [REDACTED] patient was transferred from VA Medical Center, Prescott, AZ, for replacement of an infected total hip prosthesis. His first hip replacement, done in [REDACTED], was revised in [REDACTED]. His medical history included severe rheumatoid arthritis of 20 years duration, hypertension, anemia, malnutrition and suspected pulmonary embolism. The operation to replace the infected prosthesis occurred on [REDACTED]. The estimated blood loss during the procedure was 2,700 ml. The patient received four units of red blood cells, 3,900 ml of saline and 500 ml of Hespan. Intra-operative urine output was 800 ml. The operation lasted four hours and fifteen minutes. The patient remained intubated and was transported to the SICU directly from the operating room. He was extubated at 10 p.m. and was reported to be doing well at 11 p.m.

C. Findings:

Another nurse anesthetist gave the anesthesia. The subject nurse anesthetist relieved the anesthetist of record in the final one hour and 30 minutes of the procedure and transported the patient to the SICU. A physician anesthesiologist also participated in the intra-operative management of this patient.

D. Conclusion:

All four OMI reviewers assigned a Level 1 to this case. Anesthesia care was deemed appropriate.

#### 5. Medical Record

A. Allegation: *"Collapsed. Was sent to MICU. (22 years old) Absolutely healthy."*

B. Abstract of Medical Record:

This [REDACTED] patient was admitted for repair of a ruptured anterior cruciate ligament (knee). He was markedly obese, weighing 285 pounds. Medical history included asthma, requiring hospitalization in [REDACTED]. He was given a general anesthetic, extubated in the operating room and experienced hypoxemia and wheezing immediately post-operatively. A respiratory arrest occurred 35 minutes after admission to the PACU. The patient was transferred to the MICU. He subsequently recovered without apparent sequelae.

C. Findings:

The history of asthma was not noted on the pre-anesthesia evaluation record by either the staff anesthesiologist or the subject nurse anesthetist. This lack of critical information may have contributed to inappropriate extubation in the operating room. There was no indication that broncho-dilators were used, as would have been appropriate when the patient started to wheeze.

D. Conclusions:

All OMI reviewers assigned a Level 3 to this case. The patient experienced an avoidable adverse event. A history of asthma was missed in the pre-anesthesia work-up, which compromised his care. Appropriate drug therapy was not initiated in a timely manner to treat his bronchospasm/wheezing following extubation.

**6. Medical Record**

A. Allegation: *"Collapsed in Recovery Room."*

B. Abstract of Medical Record:

This [REDACTED] patient underwent a repeat carotid endarterectomy with patch angioplasty on [REDACTED] due to re-stenosis. Following the procedure, he was extubated, and spent 55 minutes in the PACU. Vital signs were stable during this time. He was responsive, skin color was normal, and he moved all extremities appropriately. He was transferred to SICU for routine monitoring and observation, and sent to the vascular inpatient unit the following morning. The patient was discharged to home on [REDACTED].

C. Findings:

The subject nurse anesthetist was not involved in this case. Anesthesia was administered by another nurse anesthetist. Medical record documentation was excellent.

D. Conclusion:

A Level 1 was assigned to this case. The patient did well.

**7. Medical Record**

A. Allegation: *"Coded in Recovery Room. Died."*

5 .C. §  
552(b)(6)

B. Abstract of Medical Record:

5 U.S.C. §  
552(b)(6)

This [REDACTED] patient was admitted prior to operation on [REDACTED]. The medical history included diabetes, hypertension, COPD, severe peripheral vascular disease and chronic renal insufficiency. It was noted that his hypertension, more than 300 mm Hg. systolic, had not been controlled. Nevertheless, it was deemed appropriate to proceed with the planned aorto-bifemoral bypass. The patient was extubated before leaving the operating room. He was apneic and asystolic upon arrival in the PACU. Prompt resuscitative measures were instituted.

C. Findings:

This adverse event was documented in minutes of the Surgical Mortality and Morbidity (M & M) Conference, according to which the patient awakened immediately. He experienced resultant transient renal impairment, but no other residual effects. The patient did not die as a result of this incident, as alleged by the complainant. Documentation was lacking related to criteria for extubation, glucose monitoring during the operation and care provided during transport to PACU.

D. Conclusion:

The OMI reviewers assigned a Level 3 to this case. Substandard anesthesia care was provided to this patient including, but not limited to, the care provided by the subject nurse anesthetist. The care provided to this patient during transport from the operating room to the PACU was also inadequate.

## 8. Medical Record

A. Allegation: *"Collapsed. Coded in Recovery Room. Died."*

B. Abstract of Medical Record:

5 U.S.C. §  
552(b)(6)

This [REDACTED] patient had multiple admissions for COPD. He underwent an abdomino-perineal resection on [REDACTED], for ischemic proctitis and lower gastrointestinal hemorrhage. At 8:15 a.m. on the morning of surgery, the patient became hypotensive and was transferred to the SICU. He was taken to the operating room at 10:30 a.m. Anesthesia was complicated by hypothermia to 35.8° Centigrade. The patient received three units of red blood cells and 3,400 ml of fluid. Estimated blood loss was 600 ml. The patient was extubated in the operating room and taken to the SICU. The blood pressure on admission to the SICU was 97/67, respiratory rate was 24, and oxygen saturation was 91%. Less than 30 minutes following extubation, the patient had respiratory arrest and died.

C. Findings:

Extubation was premature and unnecessary because the patient was going to the SICU. Blood gases were not documented nor were other parameters that could support the decision to extubate the patient. The patient was not adequately resuscitated following his respiratory arrest in the SICU. The autopsy report concluded there was no morphological explanation for the patient's sudden death.

D. Conclusion:

All members of the OMI team assigned a Level 3 to the subject nurse anesthetist's management of this case.

## 9. Medical Record

A. Allegation:

*"Minor nasal surgery. Collapsed. Spent long time in SICU. (Supposed to be same day surgery)."*

B. Abstract of Medical Record:

5 U.S.C. § 552(b)(6)

This [REDACTED] patient had a left middle meatus antrostomy for sinusitis under general anesthesia on [REDACTED]. No complications were associated with the anesthesia. In PACU, he was medicated for pain with Demerol 25 mg IV at 2:10 p.m. and morphine 5 mg IV at 2:40 p.m. A note by a staff anesthesiologist at 2:55 p.m. states that the patient was sleepy, but readily arousable and coherent. Vital signs were stable. Immediately prior to discharge from PACU, the patient received morphine 5 mg IM at 3:15 p.m. He was noted to be unresponsive on arrival on the inpatient unit, and was treated successfully with Narcan to reverse the effects of the narcotics. He responded immediately and was admitted to the SICU for overnight observation. He was discharged from the hospital the following day.

C. Finding:

Anesthesia care during the procedure was appropriate.

D. Conclusion:

All members of the OMI team assigned a Level 1 to this case.

## 10. Medical Record

A. Allegation: *"Turned blue. Cyanotic. Pulseless. Reintubated. To SICU. (Brain dead)"*

B. Abstract of Medical Record:

5 U.S.C. §  
552(b)(6)

This [REDACTED] patient was admitted on [REDACTED] with advanced anaplastic thyroid cancer. Palliative radiation therapy was provided. The patient expressed wishes to be placed on a Do Not Resuscitate status. He died at the Medical Center on [REDACTED]. His death was not related to anesthesia. The last record of surgery with anesthesia reveals that the patient underwent a tracheotomy on [REDACTED]. The subject nurse anesthetist was not the anesthetist of record. A post-operative note by a staff anesthesiologist indicates that the patient experienced no complications at that time. On [REDACTED] documentation shows that the patient was alert and oriented.

5 U.S.C. §  
552(b)(6)

Prior to that admission, however, the patient underwent a neck exploration and resection of a mediastinal mass on [REDACTED]. Anesthesia was uneventful. The patient was extubated in the operating room. Criteria for extubation were not noted. He became bradycardic and desaturated on admission to PACU. He was treated with atropine 0.5 mg and (mask) ventilated. Blood pressures remained stable. His heart rate increased to 60, and oxygen saturations rose from 90s to 100. The patient was re-intubated. Chest x-ray revealed pulmonary edema. The patient, unresponsive at the time, was taken to the SICU.

C. Findings:

5 U.S.C. §  
552(b)(6)

Review of the record refutes the allegation that "brain death" occurred. The patient experienced an untoward response following the neck surgery in [REDACTED]. This was related to early extubation and questionable reversal of muscle relaxants in the opinion of OMI reviewers. References to the patient as alert and oriented in [REDACTED] indicate that the patient did not suffer impaired mental function as a result of the adverse event of the previous month. Records for the stay in SICU were not available to OMI reviewers, but were unnecessary to address the allegation of the complainant.

D. Conclusion:

5 U.S.C. §  
552(b)(6)

OMI reviewers assigned a Level 1 to the anesthesia care provided to the patient on [REDACTED]. OMI reviewers assigned a Level 3 to the anesthesia care provided to the patient by the subject nurse anesthetist on [REDACTED].

## 11. Medical Record

A. Allegation: "Collapsed in Recovery Room. Reintubated."

B. Abstract of Medical Record:

5 U.S.C. §  
552(b)(6)

This [REDACTED] patient with a right lower lobe pulmonary nodule underwent a wedge resection of the lung on [REDACTED]. The pathology diagnosis was *organizing pneumonia, no cancer*. Pre-operative tests showed reasonable pulmonary function except

for an oxygen saturation of 60%. The patient was a heavy smoker and retained carbon dioxide. He used bronchodilators, including Albuterol.

C. Findings:

The patient was extubated in the operating room. Criteria for extubation were not documented on the anesthesia record. In the PACU, he complained of not getting "enough air." He was re-intubated in the PACU and was transferred to the SICU. Later that evening, he was extubated successfully. The subject nurse anesthetist shared the anesthesia care in this case with two other anesthesia staff members.

D. Conclusion:

Two OMI reviewers assigned a Level 2 and two assigned a Level 3 rating to this case.

## 12. Medical Record

A. Allegation:

*Outpatient surgery for triple scope procedure. Supposed to go home the very same day, coded in the OR, brain dead. According to the witness, [the subject nurse anesthetist] forgot to give enough oxygen until too late. I did review the chart. It's true. Hypoxia caused pt's brain dead [sic] but instead family was told he had a bad heart. (Only 50 years old. No previous heart history [sic] or no mi [cardiac] medication.)*

B. Abstract of Medical Record:

This [REDACTED] patient had radical resection for cancer at the base of the tongue and radical neck dissection in [REDACTED]. A triple endoscopy was scheduled on [REDACTED]. Surgeons were preparing to do an esophago-gastro-duodenostomy when the patient went into cardiac arrest. Oxygen saturation was recorded as 97% at the time. Resuscitation was successful but the patient was noted to be in a vegetative state with irreversible anoxic brain damage. Life support was withdrawn after consultation with family members. The patient died on [REDACTED] six days after the procedure.

C. Findings:

Patient had "end-stage" cardiac disease. Autopsy revealed severe atherosclerosis of the right coronary artery as well as a large, old myocardial infarct of the left ventricle.

D. Conclusion:

While the nurse anesthetist was assigned to the procedure, the [REDACTED] [REDACTED] was also in the operating room during this patient's arrest. OMI reviewers assigned a Level 2 for the unsatisfactory cardiac work-up before the procedure.

Also, the accuracy of the documentation during anesthesia was questioned by two of the OMI reviewers.

### 13. Medical Record

#### A. Allegation:

The OMI team reviewed the medical record of this patient because of a copy of a letter alleged to have been sent to the veteran's family accusing "a very careless nurse anesthetist" of negligence. The letter was attributed to the "Veterans' Friends, Phoenix VA Medical Center, Phoenix, AZ 85012," on February 13, 1999.

#### B. Abstract of Medical Record:

This [REDACTED] veteran underwent a laparoscopic right inguinal hernia repair on [REDACTED] under general anesthesia. His anesthesia classification was ASA 3<sup>3</sup> and he had a long history of substance abuse. On [REDACTED] the patient became acutely agitated and required restraints. On [REDACTED] it was noted that he had bilateral pulmonary infiltrates and evidence of pulmonary edema. He was treated with sedation and diuretics.

#### C. Findings:

The patient was extubated in the operating room and re-intubated in the PACU. He was also extubated in the PACU several hours later.

#### D. Conclusions:

Criteria for extubation were not documented on the anesthesia record. The OMI team felt that the anesthesia was not adequately reversed. Three OMI team members assigned a Level 2. One OMI team member assigned a Level 1.

### 14. Medical Record

#### A. Allegation:

This patient was identified by the Medical Center as the patient cited in the aforementioned letter from U. S. Office of Special Counsel to the Secretary of Veterans Affairs. The anesthesiologist complainant described this patient to illustrate the type of anesthesia care provided by the subject nurse anesthetist to a patient undergoing total hip replacement. He alleged that the subject nurse anesthetist was "in the room, but not monitoring the patient." He alleged also that the subject anesthetist altered the anesthesia record to

<sup>3</sup> American Society of Anesthesiology ranking of the anesthesia risk based on patient's medical status. An assignment of 3 represents significant impairment of one organ system, e.g., cardiac, pulmonary, etc.

record normal blood pressures. Finally, when blood was needed for transfusion, the complainant said that blood was not immediately available.

B. Abstract of Medical Record:

5 U.S.C. § 552(b)(6) This [REDACTED] veteran was admitted on [REDACTED] for surgery for degenerative joint disease of the right hip. On [REDACTED] a right total hip arthroplasty was done under spinal anesthesia. He received one unit of red blood cells in the PACU and two units of red blood cells on [REDACTED]. He was discharged from the hospital to the VA nursing home on [REDACTED]. He was able to walk with assistance.

C. Findings:

During anesthesia, the patient's blood pressure gradually fell over a period of three hours. The patient's vital signs then stabilized during the fourth hour. In the PACU, the patient's hemoglobin (Hgb) was 10 G, and he was transfused one unit of red blood cells.

Item 4 on the consent form (SF 522) asking the patient if there were any *exceptions to surgery or anesthesia* was not completed, and the printed name of the individual who obtained the informed consent was not recorded on the reverse side, as required.

D. Conclusion:

OMI reviewers could not substantiate the allegation that the nurse anesthetist was "not monitoring the patient," nor could the allegation of altering the medical records be substantiated. The OMI reviewers assigned a Level 2 to the nurse anesthetist for not assuring the immediate availability of blood.

**Summary of the OMI Review of the 14 Medical Records**

Of the 14 medical records reviewed by the OMI team:

- 2 patients were anesthetized by another nurse anesthetist.
- 3 patients had more than one anesthetist or anesthesiologist, including the nurse anesthetist.

- 9 patients were anesthetized by the subject nurse anesthetist, and the following ranking scores were assigned by the OMI team members:
  - ✓ 2 - Level 1 (Most practitioners would have given anesthesia care the same way.)
  - ✓ 1 – Level 1/2 (OMI team members assigned both a Level 1 and Level 2.)
  - ✓ 2 – Level 2 (Some practitioners would have given anesthesia care differently.)
  - ✓ 1 – Level 2/3 (OMI team members assigned both a Level 2 and Level 3.)
  - ✓ 3 – Level 3 (Most practitioners would have given anesthesia care differently.)
- Of the 14 patients, 3 patients died.

## VII. OMI Findings at the Site Visit in September 1999

The OMI team members identified the following at the time of the site visit in September 1999:

- The positions of the Chiefs of Surgery and Anesthesia remained unfilled.
- According to interviews with nurses from the PACU and the ICU, the subject anesthetist's patients were brought to the PACU incompletely "reversed" from their anesthetized state in greater numbers than those of his peer anesthetists. There were "more breathing problems" in the subject nurse anesthetist's patients than in the other nurse anesthetists' patients.
- Relevant log books documenting PACU occurrences "had disappeared" from the shelves of the PACU and allegedly from the Medical Center's premises.
- The subject nurse anesthetist was heard to speak about some veteran patients in a deprecating and insulting manner.
- In his interaction with many of the nursing staff in operating rooms, the PACU and the intensive care unit, the subject nurse anesthetist was depicted as "brusque, intimidating, moody and volatile."
- There were no proficiency reports evaluating the performance of the subject nurse anesthetist for the last two years. The last record of his proficiency was in 1997. He received [REDACTED] rating in the overall assessment.

5 U.S.C. §  
552(b)(6)

- During the interview with the subject nurse anesthetist, he stated that his superiors never made him aware that he had more patients who required re-intubation in the PACU than his colleagues or that he had “performance problems.”
- An anesthesia quality improvement program was initiated in March 1999. One of the performance measures is: *The patient requires re-intubation in the PACU/SICU*. It was noted that in the months of June, July, and August 1999, “there were no re-intubations.” In the previous quarter, there were five. The measurement is being continued.
- Since March 1999, the Acting Chief of the Anesthesia Section had established a mentoring process with the subject nurse anesthetist and “was monitoring his cases closely.” He indicated that he would continue to do this for an indefinite period.

### **VIII. Summary and Conclusions:**

The Summary and Conclusions are presented as specified in the reporting requirements of 5 U.S.C., Section 1213d.

#### **1. A summary of the information with respect to which the investigation was initiated:**

The Medical Inspector responded to an inquiry from the United States Office of Special Counsel (OSC) to the Secretary of Veterans Affairs, dated August 4, 1999, regarding allegations against a nurse anesthetist made by an anesthesiologist (complainant) at the Carl T. Hayden VA Medical Center, Phoenix, AZ (the Medical Center). The anesthesiologist claimed that the nurse anesthetist’s “negligent behavior has caused at least 4 patient deaths, and has resulted in the collapse of at least another 8 patients after surgery.” Information provided to OSC by the anesthesiologist was considered to demonstrate “a substantial likelihood that a substantial and specific danger to public health and safety exists at the Medical Center.”

#### **2. A description of the conduct of the investigation:**

- a) A site visit to the Medical Center in September 1999 was conducted by two staff members from the Office of the Medical Inspector (OMI) and three surgery and anesthesia consultants who are nationally recognized for their clinical expertise.
- b) Medical records of 14 patients were reviewed, 12 of which were listed by the anesthesiologist in information he provided to the OSC. Two additional medical records were reviewed on site.
- c) Interviews were conducted with senior management staff, the Acting Chief of Surgery, the Acting Chief of Anesthesia, nurse managers, operating room nurses, nurse anesthetists, post-anesthesia care unit (PACU) nurses, quality management staff, a staff anesthesiologist, the complainant and his attorney, and the subject nurse anesthetist.

- d) Quality improvement documents and minutes of Anesthesia Mortality and Morbidity Conferences were reviewed.
- e) Personnel Folders of the nurse anesthetists were reviewed to determine dates of their last proficiency ratings.

**3. A summary of any evidence obtained from the investigation:**

- a) Sub-standard anesthesia care was provided in six of 14 cases<sup>4</sup> in which the subject nurse anesthetist participated over a period extending from 1993 to 1999. Although not solely responsible for this substandard care, interviews with PACU staff members confirmed that he had anesthesia care incidents in the PACU in numbers greater than the other five nurse anesthetists.<sup>5</sup>
- b) Premature endotracheal extubation at the end of anesthesia appeared to be the primary problem in six patients. Criteria for endotracheal extubation at the end of anesthesia were not in place at the Medical Center during this period.
- c) Staff confirmed that the nurse anesthetist in question had behavioral issues, and was at times brusque, intimidating, moody, bullying and volatile. Also, the subject nurse anesthetist was heard to speak about some veteran patients in a deprecating, insulting manner.
- d) The Medical Center lacked a plan and a process to measure and assess data regarding anesthesia quality issues during the period from 1993-1999. The former Chief of the Anesthesia Section performed reviews, but on a case-by-case basis. There were no documented Anesthesia Mortality & Morbidity (M & M) Conferences before March 1999.
- e) Actions by the former Chief of the Anesthesia Section (and by the former Chief of Surgery) regarding anesthesia quality of care issues were ineffectual or absent. Nursing staff told OMI team members that they reported post-anesthesia quality of care issues to their superiors. However, no actions were taken. The Chief of Staff claimed that he was unaware of problems in the Anesthesia Section until the time of the initial site visit by the OMI in March 1999.
- f) There were significant reductions in anesthesia-related incidents in the six-month period from March to September 1999. For example, there were no re-intubations in the PACU for the three months of June, July and August 1999.

**4. A listing of any violation or apparent violation of law, rule or regulation:**

Failure to provide a proficiency rating for the subject nurse anesthetist since January 1997 violates policy and procedural requirements authorized by 38 U.S.C. 501 (a), 7421, and set forth in VA's MP-5, Part II, Chapter 6, entitled Proficiency Rating System, dated October 30, 1998.

**5. A description of any action taken or planned as a result of the investigation, such as:**

- a) **changes in agency rules, regulations or practices;**

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<sup>4</sup> The complainant cited twelve of the 14 cases; an additional two were identified during the site visit.

<sup>5</sup> Six nurse anesthetists administered approximately 95% of the anesthesia at the Medical Center.

The OMI is evaluating the need to recommend that standardized guidelines for extubation at the termination of anesthesia be applied throughout Veterans Health Administration facilities.

**b) the restoration of any aggrieved employee;**

Not applicable

**c) disciplinary action against any employee;**

Continued close supervision and monitoring of the nurse anesthetist is recommended.

**d) referral to the Attorney General of any evidence of a criminal violation.**

Not applicable

**6. Management initiatives related to this review include the following:**

- a) The Medical Center accepted the resignation of the former Chief of Anesthesia on February 27, 1999.
- b) A contract for anesthesia services was established immediately. The new Acting Chief of Anesthesia began in March 1, 1999.
- c) Regular Anesthesia M & M Conferences began in March 1999. The minutes of the conferences contain reviews of anesthesia quality of care issues with recommendations and actions.
- d) Effective supervision and monitoring of the subject nurse anesthetist by the new Acting Chief of the Anesthesia Section began in March 1999, and is continuing.
- e) Criteria for endotracheal extubation were being developed by Anesthesia staff members at the Medical Center in September 1999.
- f) Systematic data collection on specific anesthesia care performance measures (indicators) was begun in June 1999

**7. OMI Conclusion:**

The Medical Inspector concludes that the allegation that the nurse anesthetist's "negligent behavior has caused at least four patient deaths, and has resulted in the collapse of at least another eight patients after surgery" is incorrect. The nurse anesthetist participated in the anesthesia in six of the 14 cases reviewed by the Office of the Medical Inspector in which there was a question concerning the quality of anesthesia care. Of the 14 patients, three died. Based on the review of medical records, interviews with clinical and management staff, the review of personnel folders and quality improvement documents, the Medical Inspector found no evidence that the nurse anesthetist's "negligent behavior caused" the three patient deaths. The nurse anesthetist was not solely responsible for the substandard care provided in any of the six instances identified during the investigation.



DEPARTMENT OF VETERANS AFFAIRS  
Veterans Health Administration  
Washington DC 20420

MAR 16 2000

Karen Gorman  
U.S. Office of Special Counsel  
1730 M Street, N.W.  
Suite 300  
Washington, DC 20036-4505

In Reply Refer To: 10MI

Re: QSC File No. DI-99-0748

Dear Ms. Gorman:

I am responding to your recent request to Kathleen Heaphy, VA Office of General Counsel, for an update on actions taken as a result of the investigation conducted by the Office of the Medical Inspector (OMI) at the Carl T. Hayden Medical Center in Phoenix, AZ. This investigation addressed concerns raised by the Special Counsel in a letter to the Secretary, Department of Veterans Affairs, in a letter dated August 4, 1999. Actions taken on items 5.a and c and 6.a through f, as listed in the Special Report to the U.S. Office of Special Counsel, dated December 9, 1999, page 17, will be addressed.

Item 5. a - addresses the OMI's evaluation of the need to recommend standardized extubation guidelines ----- . The OMI determined that these guidelines are already in place, and no further system-wide action is required.

Item 5.c - addresses disciplinary action against any employee. In this case, the subject Certified Registered Nurse Anesthetist (CRNA), as well as the other CRNAs, remains under appropriate supervision and performance monitoring by the Acting Chief, Anesthesia Section. The subject CRNA received a proficiency rating of highly satisfactory in January 2000. A supervising CRNA also has been appointed to assist in these functions and to address learning needs of the group. No problems have been identified. Anesthesia staff members have completed an Airway Study, focusing on reintubation in the immediate post-operative period. They are considering publication of the study.

Item 6 addresses management initiatives related to this review. Updates on specific actions follow:

- (6a). A highly qualified Acting Chief, Anesthesia Section has been in place since March 1999. This physician remains on contract. Efforts to recruit a permanent VA physician anesthesiologist continue. OMI staff were informed that the salary that can be offered by the Medical Center is below that available in this highly competitive health care market. The

Acting Chief has earned the respect of colleagues and staff. He has demonstrated the skills and commitment needed to improve the quality of care and management practices, greatly needed in the Anesthesia Section;

- (6b). Contract services for anesthesia continue. Valley Anesthesia continues to provide highly qualified anesthesiologists to provide patient care. Working relationships and communication between the physicians and the CRNAs have improved;
- (6c). Monthly Anesthesia Mortality and Morbidity (M and M) Conferences began in March 1999, and continue. Anesthesiologists, CRNAs and quality management staff attend these conferences. Minutes reflect reviews of anesthesia quality of care issues and performance indicators. Corrective actions and follow-up are included in the minutes;
- (6d). Effective supervision and monitoring of the subject CRNA continues, as described above;
- (6e). Criteria for endotracheal extubation were developed and implemented by anesthesia staff at the Medical Center in September 1999. They are incorporated on the updated anesthesia form in the medical record now used at the facility.
- (6f). Systematic data collection on performance measures in anesthesia began in June 1999, and continues. Findings and any actions needed for improvement are discussed at regular M and M Conferences and meetings. No patterns or trends have been identified.

Please contact me if you need additional information. I can be reached at 202.273.8940.

Sincerely,

  
James E. McManus, M.D.  
Medical Inspector