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STATEMENT OF
T C DOHERTY
MEDICAL CENTER DIRECTOR FOR THE
MIAMI VETERANS AFFAIRS MEDICAL CENTER
ON THE VETERANS HEALTH ADMINISTRATION'S
POLICY AND PERFORMANCE
RELATING TO SPECIFIC PATIENT INCIDENTS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

October 8, 1997

Mr. Chairman and Members of the Subcommittee:

I appreciate the Subcommittee's consideration of the serious case before it today.

In June 1996, Mr. John Floyd Martin, a hemodialysis patient being treated by the VA for more than 25 years, died during one of his dialysis treatments at the Miami VA Medical Center as a result of a massive blood loss. When informed of Martin's death, I immediately convened a Board of Investigation. Later, a Root Cause Analysis was completed. A brief summary of the nature of the circumstances of the case; the findings and conclusions related to the case; and the remedial steps taken follow.

It should be noted that prior to the tragic death of Mr. Martin, the outcome statistics for the Miami VAMC Dialysis Unit were above the national average, and our mortality rates are below the national average. In addition, there had been no adverse events related to staff performance in the estimated 135,000 dialysis treatments that have been performed since the unit opened in 1966.

I. Nature of the Circumstances of the Case.

On Saturday June 22, 1996, the dialysis nurse who was scheduled to give Mr. Martin his dialysis treatment arrived a few minutes late for duty. She immediately proceeded to connect Mr. Martin to the dialysis machine. She observed a problem with the venous pressure transducer. Unable to resolve the transducer problem, the nurse requested assistance from a dialysis technician. They worked together to correct the problem. During this process, the dialysis nurse was notified that she had a telephone call. She left the bedside to answer the telephone in the nurses' station. The dialysis technician remained at the bedside, troubleshooting the machine. The nurse completed her call and returned to the bedside. The technician replaced the transducer and was leaving the area, when she heard a hissing sound. She returned to the patient's bedside and observed blood overflowing from the 2-liter collection container located on the side of the dialysis machine. The nurse and the technician investigated and discovered that the venous dialysis line was not connected to the return port in the patient's vascular access. The primary nurse had failed to connect the venous line to the patient. This resulted in the loss of more than 1800cc of blood. The nurse and the dialysis technician then attempted to replace the blood loss with large amounts of physiologic saline.

The dialysis technician proceeded to clean up the blood spill. The blood-filled container was removed from the dialysis machine for disposal by the dialysis technician who called a second nurse to show her the blood-filled container and informed her that the blood was Mr. Martin's. The second nurse

immediately rushed to Mr. Martin's bedside to assist. The technician emptied the container of blood and returned to the bedside to complete cleaning the area.

The patient appeared to stabilize briefly after the administration of saline. During the course of these events, one of the above-mentioned three staff members obtained a blood sample and sent it to the laboratory for determination of hematocrit.

An employee of the Environmental Management Service arrived on the Dialysis Unit at approximately 7:15 a.m. and proceeded to clean the area. He stated that he spoke to Mr. Martin when he first approached the bedside and that the patient responded to his greeting. He stated however, that when he left the area, "the patient didn't look good."

The patient's condition began to rapidly deteriorate. A third dialysis nurse was called to the scene from a separate room to assist with the care of the patient. She was not informed of the blood loss. Shortly thereafter, at approximately 7:30 a.m., a dialysis nurse called a code.

The code team physician reported that when he arrived on the scene, the other team members had already started the appropriate life saving measures. He stated that he questioned the staff at the bedside as to what had happened. He was told that the patient had developed abdominal pain followed by hypotension (low blood pressure). All three individuals (Mr. Martin's nurse, the second dialysis nurse, and the dialysis technician) knowingly withheld information concerning the blood loss from the code team. Knowledge of the loss would have been of great importance to the team in the proper assessment and management of the patient. At no time during the code did any one of the three caregivers inform the code team that the patient had lost a large quantity of blood or that it was replaced with physiologic saline. The patient was pronounced dead at 8:25 a.m. June 22, 1996 by the code team physician.

At approximately 9:30 a.m., the nephrology fellow questioned the nursing staff involved in this incident. They failed to advise him that the patient had lost blood, or to provide him with the flow sheet documentation of the dialysis treatment. The staff also failed to notify the Chief of the Nephrology Section of the blood loss when he questioned them at approximately 11:30 a.m.

On the morning of the incident, Mr. Martin's primary nurse called her supervisor (the Nurse Manager of the Dialysis Unit) at home and informed her about the incident. There is conflicting testimony as to what was actually relayed during the conversation.

The second dialysis nurse called the Nurse Manager of the Dialysis Unit at home the following day to inform her of the extent of the patient's blood loss. The Nurse Manager of the Dialysis Unit instructed the second dialysis nurse to report to work on Monday, June 24, 1996 (her scheduled day off) to further discuss this incident.

The Nurse Manager of the Dialysis Unit failed to inform her supervisor of the incident until the afternoon of Tuesday, June 25, 1996..

II. Findings and Conclusions Related to the Case.

Proximate factors contributing to Mr. Martin's death were massive blood loss and the cover-up of the blood loss. In addition, there were other factors that are believed to be related to this tragic event.

A. The Massive Blood Loss.

1. The patient lost in excess of 1800cc of blood during his dialysis treatment over a period of approximately 10 minutes between 6:45 a.m. and 7:00 a.m. This blood loss occurred because Mr. Martin's nurse failed to close the dialysis blood circuit.
2. In addition, Mr. Martin's nurse left the patient's bedside during the critical set-up phase of the dialysis treatment, without assuring appropriate care of the patient.

B. The Cover-Up of the Blood Loss.

Mr. Martin's nurse, the second dialysis nurse, and the dialysis technician were negligent when they attempted to handle the emergency upon discovery of the blood loss, without immediate notification of a physician, and when they did not inform the Code Team about the massive blood loss.

C. Other Related Factors.

1. The Nurse Manager of the Dialysis Unit failed to notify proper authorities in a timely manner.
2. The Dialysis Unit that was operational at the time of the incident was separated into two main areas that were divided by a corridor. The geographical division did not permit optimal observation of all patients by all staff members.

III. Remedial Steps Taken.

A. Personnel Actions.

1. Mr. Martin's nurse, the second dialysis nurse, the Nurse Manager, and the dialysis technician were immediately removed from the Dialysis Unit, pending the outcome of the Investigation.
2. Mr. Martin's nurse was terminated and the State Licensing Board was notified.
3. The second dialysis nurse was suspended for 30 days and permanently reassigned. She resigned.
4. The Nurse Manager of the Dialysis Unit was suspended for 14 days, and was reassigned.
5. The dialysis technician was suspended for 14 days.

B. Other Remedial Actions.

1. Dialysis treatments were moved to a newly constructed Dialysis Unit, which had been planned prior to the incident. This provides increased accessibility and visibility of staff to patients. The open design of the new unit permits staff to assist each other in the event of an emergency while ensuring patient privacy.
2. A total reorganization of nursing staff within the Dialysis Unit, including a new nurse manager and four new staff members, has taken place following the death of Mr. Martin.
3. The critical set-up process for dialysis has been redesigned to ensure a more uniform approach among all staff members and with all patients. A flow sheet was developed during the Root Cause Analysis to graphically represent the critical elements in the set-up process, particularly those involving the clamping of venous and arterial lines. The flow sheet clarified the need for nurses to stay with the patient throughout the critical phase of the treatment and it is displayed at each patient's dialysis treatment location. Ongoing monitoring of the revised critical dialysis set-up process has been initiated. Since the onset of the tracking, there has been 100% compliance with the set-up process.
4. Leadership issues on the Dialysis Unit have been addressed. Specifically, leadership training for the recently hired Nurse Manager and for designated charge nurses has been instituted. One-on-one mentoring for both the Nurse Manager and the charge nurse by the Associate Chief Nurse (ACN), Special Care has been ongoing. The nurse manager has received a formal supervisory training course from Human Resources specialists. The charge nurse and of all of the current RNs are participating in a nationally developed basic leadership development program which is being held over a six-month period.
5. Meticulous attention to all aspects of conformance to policies and procedures has been in effect since this tragic incident even though prior to Mr. Martin's death, monitoring activities did not reveal evidence of inappropriate patient care. Dialysis staff members have received on-going staff training in administrative policies and procedures, emergency procedures, dialysis procedures,

incident reporting, and accepting personal telephone calls. Subsequent to the incident, all dialysis nurses have achieved certification in Advanced Cardiac Life Support (ACLS). Fifty percent of the current dialysis staff nurses have received national certification in Nephrology Nursing. Ethics classes for dialysis staff and others have been provided by The National Center for Clinical Ethics.

6. The Chief, Dialysis Unit; the ACN, Special Care; and the Nurse Manager of the Dialysis Unit meet regularly with all staff members to ensure accurate communication.
7. Modifications in the culture of the Dialysis Unit have been made. The new dialysis team is functioning effectively to provide safe, competent care to veterans. The entire interdisciplinary dialysis team collaborated to revise and improve the dialysis order forms and documentation forms and to update 100% of the dialysis policies and procedures utilizing the most recent dialysis science data. All registered nurses on the Dialysis Unit are reviewing patient charts as part of the peer review process to ensure continued quality. Patients, when questioned, express satisfaction with their care. A plan for all members of the interdisciplinary dialysis team to participate in a team-building program presented by Project Challenge is underway to advance the positive, cohesive team spirit that has been developed.

IV. Conclusion.

From Mr. Martin's death, we at the Miami VAMC have learned many lessons. We have taken remedial personnel actions, have improved the Dialysis Unit's operating procedures, and have conducted intensive education and training of staff members.

Again, thank you for allowing me to explain the circumstances surrounding this tragic deviation from the high quality care that has been the hallmark of the care provided to our veterans in the thirty-one years since the Dialysis Unit opened.

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