Office of Congressional & Legislative Affairs

Testimony & Legislation

STATEMENT OF
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MEDICAL CENTER DIRECTOR FOR THE
MUSKOGEE VETERANS AFFAIRS MEDICAL center
ON THE DEATH OF A PATIENT AT A CONSTRUCTION SITE
ON MAY 24,1996 AT
THE VAMCMUSKOGEE, OKLAHOMA
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 weighty responsibility for oversight of the VA healthcare system and fully understand concerns regarding uncommon, isolated events resulting in a patient's death.

The staff of the medical center were deeply saddened by the untimely death of the patient. This tragedy was highlighted in various news medias and provoked anxiety among the staff for many months. Although an unfortunate event, it was the only such accident that has occurred of its nature having to do with patient safety. The coverage of this isolated incident far outshadowed the compassionate care delivered by our staff each and every day to hundreds of veterans. In keeping with our mission, our staff continue to "provide personalized, high quality care with dignity and compassion."

The patient was a 65 year old male with an admitting diagnosis of gastrointestinal bleeding and chronic alcohol abuse. He was brought to the Emergency Care and Treatment area at the Muskogee VAMC at 7:15 p.m. on May 22, 1996, complaining of abdominal pain, nausea, vomiting and diarrhea for two to three days. He had a history of chronic alcohol abuse and had alcohol on his breath. Vital signs were taken. A naso-gastric tube was inserted, intravenous fluids were begun with intravenous famotidine (Pepcid) and he was transfused with two units of red blood cells. He received one injection of 50 mg of chlordiazepoxide (Librium) for restlessness. On May 23, 1996 the naso-gastric tube was removed. He was able to take clear liquids by mouth and was allowed out of bed in a wheel chair. On May 24, 1996, he was further improved and stated he was hungry. He was started on oral feedings with supplementary potassium and phosphate and begun on oral famotidine (Pepcid).

The patient's medical condition had improved significantly since his admission. He had interacted appropriately with staff. He was judged to be appropriately oriented as to place, time and person. He was receiving no sedation, relaxants, or psychoactive medications. He was growing increasingly independent from his wheel chair, using it only for short rest and usually walked behind it. Staff were sure that the patient was oriented and competent to make his own decisions.

Prior to the time of the incident, his hospital stay was uneventful, with all activities of care well coordinated and timely. On May 24, 1996, around 10:30 p.m., the patient left the ward without informing the nurses, possibly to smoke. This patient was a smoker and left the ward on several occasions to smoke. When he did not return within approximately 15 minutes, a search was conducted but the patient was not located. On May 25,1996, at around 8 a.m., the patient was found dead in the construction site.

The local Muskogee police and the VA police both investigated the incident immediately. The Medical Center convened a Board of Investigation June 3-7, 1996, and the Office of the Medical Inspector conducted a site visit on June 26-27, 1996.

The local police department investigated the death and ruled it accidental. The Board of Investigation and the VAMC police also found the death as accidental.

Findings of the Administrative Board of Investigation resulted in the following recommendations and subsequent actions by management.

- All patients are to be assessed for risk of wandering or falls at the time of admission and reevaluated routinely. This is to be documented in the medical record. ***(Managerial response - Policy was revised to ensure all patients were assessed for wandering and/or falls and that medical records indicate the assessment. There is ongoing monitoring for compliance.)***

- The instructions provided to patients upon admission should be documented in the medical record, including instructions regarding appropriate smoking areas. ***(Managerial response - Documentation of orienting the patient to this requirement is reflected on the Nursing Admission Assessment Form and on the Multidisciplinary Patient/Family Education Safety Tracking Flow Sheet.)***

- All patients should be cautioned to avoid all areas adjacent to the construction site. ***(Managerial response- A letter was developed stating the dangers. This letter continues to be distributed to every patient entering the medical center and is posted throughout the medical center.)***

- All staff with the potential to serve as a coordinator in a missing patient search should receive annual training on VA and medical center search policies and procedures. ***(Managerial response - This has been addressed in the new policy. All staff have received formal education and will receive annual updates.)***

- In addition to the interim recommendations made by the Safety Committee on 5/28/96, a formal assessment of the environment of care should be made in the areas of security, life safety and construction management. ***(Managerial response - Formal assessments were completed and are contained as Tabs 13, 14, and 15 in the documents submitted to Mr. Cliff Sterns.)***

- Signage indicating "This door locks automatically behind you" should be placed on all applicable exit doors. ***(Managerial response - Appropriate signage was developed and installed.)***

- Policies (i.e., MCMs and service-level) pertaining to search procedures should be reviewed and modified as needed to minimize any potential areas of ambiguity or weaknesses. ***(Managerial response - New policies were developed and continue to be revised as necessary. An inservice for all staff on the new policy was conducted by the Safety and Occupational Health Manager and incorporated in the annual training program. See Tabs 21 - 26.)***

Following the Administrative Board of Investigation, the Office of Medical Inspector (OMI) conducted an investigation. This was in response to the family's request for an investigation from OMI. In response to

this request the Deputy Under Secretary for Health asked the Medical Inspector to determine if the VAMC's actions prior to and subsequent to the death were in compliance with VA policy and to review the Board of Investigation's report and other evidence to determine if a full site team visit and investigation by the OMI were needed.

The OMI reported the following findings in their final report dated February 12, 1997, which is contained in the reference book sent earlier to the Subcommittee.

The OMI determined that prior to the event of May 24, 1996,the patient had been allowed appropriate independence in movement. It was on that date the patient found himself locked out of the hospital when he went outside to smoke. While other options for reentry were available, such as calling for help from a telephone in a well-lit smoking shelter or waiting in the smoking shelter until someone came looking for him, he apparently tried to find a path back to the front door. "After squeezing through the seam between two sheets of construction fencing," (it was later determined he had unfastened metal ties connecting the fence), he walked around part of the perimeter of a construction hole. He fell 35 feet into the construction hole where he was impaled on an uncapped steel rebar imbedded in concrete. His decision to force his way into a construction site, which was clearly marked as dangerous, exposed him to the hazards that resulted in his death. Maintenance of the construction site by the independent contractor was brought into question by the Board of Investigation; however, some of the citations and findings of that Board were corrected or questioned by the VHA Chief of Facilities Maintenance Officer and found to be unsubstantiated.

The patient's absence was almost immediately noted by the ward staff, and search procedures were implemented. The patient, however, was not found until the next morning.

The Office of Medical Inspector found that the Medical Center and local police conducted complete and thorough investigations.

Based on the review by the Medical Center and OMI's concurrence with the Medical Center's findings, the following recommendations were made:

1. All doors, which lock behind those exiting should be clearly marked as such. In the event that a patient, staff, or visitor is inadvertently locked out, instructions on how to regain entry should be posted on the outside of the door. ***(Managerial response - All exit doors, which lock behind those exiting, have been clearly marked.)***

2. Search procedures should be expanded to include any closed-off construction areas to determine if the perimeter is intact. ***(Managerial response - The Medical Center Search Policy was revised to include a search of the perimeter of any construction area.)***

3. All hazardous areas, such as construction sites must be fully lighted at night. ***(Managerial response - The construction area is illuminated by a flood light The Medical Center Search Policy includes a search of all construction sites. Corrective action was taken immediately following the incident.)***

4. Consideration should be given to requiring patients to sign out when leaving the ward, at night and on weekends. ***(Managerial response - Patients are required to sign out when leaving the ward. Monitors are in place to ensure compliance. Corrective action was taken immediately following the incident.)***

5. Medical Centers should develop a mechanism to limit acute care patients, who wish to smoke, to designated smoking areas outside the building. ***(Managerial response - Orientation for patients pertaining to the Medical Center Smoking Policy, location of patient smoking shelters and uses of sign-out sheets was implemented as a result of the Medical Center Administrative Investigation. Appropriate nursing staff received education and training for this orientation.)***

Recommendations were made to VHA to incorporate much of what was recommended to the VAMC into VA policy. All VAMCs should be directed to review the foregoing recommendations as an alert to prevent a similar tragic accident.

The Medical Center took immediate action to comply with all recommendations set forth in the administrative investigation and the Medical Inspectors Report. As indicated in the reference material sent to the Subcommittee earlier, and in my testimony today, search policies were followed appropriately. Policies have been modified to delete any areas which may have been ambiguous and training for the entire staff of the Medical Center has taken place and will continue to be a part of the annual training each Medical Center employees goes through.

Our Risk Management Program is aimed at improving the quality of care through identification of system design flaws and other problems and redesign of patient care systems to decrease the likelihood of deviations that can harm patients. Our Medical Center, like all medical centers and VISNs throughout the country is in the process of revising our Risk Management Program to comply with the new National Risk Management Directive and the VISN 16 Risk Management Policy. We have a designated Quality Management Specialist who serves as our facility's Clinical Risk Manager and a full time Safety Officer. We participate in an exchange process whereby we have the benefit of review from other VA facilities and also perform reviews for them when requested. We have a formal process, which follows the guidelines set forth in the National Risk Management Directive for reporting any events that are, or may become, high profile to our VISN within 24 hours. In addition, the Quality Managers from VISN 16 had a meeting in Dallas where our Quality Manager gave a presentation on Risk Management related to these events. So as you see we have an elaborate and extensive network for reviewing, improving, and evaluating our potential for risk. As directives are finalized, staff will be educated on the changes.

It is unfortunate that this accident occurred, and we have taken steps to minimize the possibility of any reoccurrence.

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