



# Department of Veterans Affairs Office of Inspector General

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## Healthcare Inspection

### Review of an Unexpected Death North Chicago VA Medical Center North Chicago, Illinois

**To Report Suspected Wrongdoing in VA Programs and Operations**

**Telephone: 1-800-488-8244 between 8:30AM and 4PM Eastern Time,  
Monday through Friday, excluding Federal holidays**

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## Executive Summary

The purpose of the review was to determine the validity of allegations regarding the care provided to a patient who died within 24 hours of admission to the North Chicago VA Medical Center (the VAMC). The complainant suggested that a medical trainee may have been inadequately supervised.

We found deficiencies in the quality of care provided for this patient, but we did not demonstrate a connection with the patient's death. A physician conducted an evaluation approximately 5 hours before the patient's cardiopulmonary arrest, but the patient's subsequent restlessness and hypoxemia should have prompted an assessment of underlying causes prior to administration of an intravenous (IV) sedative. The sedative and an IV narcotic were administered at reasonable doses, but this combination might best have been avoided during a pursuit of an explanation for his restlessness and hypoxemia. Although the VAMC has a procedure in place for the expeditious assessment of patients whose condition is worsening, physician and nursing personnel did not take advantage of this resource.

We recommended that management officials evaluate this case with Regional Counsel for possible disclosure to the patient's family and ensure that staff comply with the VAMC's policy for rapid intervention in patients with deteriorating clinical conditions. Management submitted appropriate implementation plans.



**DEPARTMENT OF VETERANS AFFAIRS**  
**Office of Inspector General**  
**Washington, DC 20420**

**TO:** Director, VA Great Lakes Health Care System (10N12)

**SUBJECT:** Healthcare Inspection – Review of an Unexpected Death, North Chicago VA Medical Center, North Chicago, Illinois

## **Purpose**

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) received allegations regarding the death of a veteran soon after admission to the North Chicago VA Medical Center (the VAMC). The purpose of this review was to determine whether the allegations had merit.

## **Background**

The VAMC, part of the VA Great Lakes Health Care System (also known as Veterans Integrated Service Network (VISN) 12), provides care for veterans in northeastern Illinois and southeastern Wisconsin. The medical center also serves Department of Defense beneficiaries affiliated with the Naval Station Great Lakes. The VAMC is affiliated with the Rosalind Franklin University of Medicine and Science, Loyola University Chicago, and the University of Illinois.

A complainant reported concerns about the care provided to a veteran who died within 24 hours of admission to the VAMC. The complainant made no specific allegations about quality of care but suggested that a medical trainee may have been inadequately supervised.

## **Scope and Methodology**

We interviewed the complainant by telephone and reviewed patient medical records. We also reviewed VAMC policies and quality management documents pertinent to the case. We performed the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

## Inspection Results

### Case Summary

A middle-aged man with a history of osteoarthritis of the hip, obstructive sleep apnea, and morbid obesity presented to the VAMC Emergency Department (ED) at 4:00 a.m. on a Sunday morning complaining of continuing left hip and leg pain. He stated that 3 days earlier he had received a steroid injection at a private facility, but that the pain had persisted. In the 2 months prior to this presentation he had been treated in the ED for the same problem on 12 occasions.

In the ED he was described as having no pain approximately 30 minutes after receiving an intramuscular injection of ketorolac,<sup>1</sup> although he had been admitted to the hospital for pain control. It was noted that he lived alone.

Following admission to the hospital, nursing documentation indicates that the patient was eating well and walking in the hall. Recurrent pain was well-managed with intravenous (IV) hydromorphone.<sup>2</sup> Approximately 14 hours after admission, an attending physician documented that he had discussed the patient with the resident physician (resident) and concurred with the plan of care.

Approximately 22 hours after admission (5:05 a.m.), in a progress note describing events of the previous few hours, a registered nurse documented that the patient was:

Restless, keeps getting up in bed and walking drowsy. Oxygen applied but [patient] takes it off. Dozing on and off while sitting at the edge of the bed and while walking.

The nurse noted that the on-call resident physician “came to assess the patient,” but the resident did not document the encounter. Because the patient was considered to be at high risk for falling, at 1:00 a.m. the resident physician ordered 1:1 observation.

A registered nurse recorded that the following medications were administered: zolpidem<sup>3</sup> 5 mg (2:29 a.m.), hydromorphone 4 mg IV (2:45 a.m.), and lorazepam<sup>4</sup> 2 mg IV (4:37 a.m.). The patient’s oxygen saturation was noted to fall below 90 percent, and oxygen flow was increased from 2 to 4 liters/minute (administered by nasal cannula<sup>5</sup>). The patient was noted to be asleep at 5:00 a.m.

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<sup>1</sup> A nonsteroidal anti-inflammatory drug.

<sup>2</sup> A narcotic analgesic.

<sup>3</sup> An oral medication for sleep.

<sup>4</sup> A sedating medication.

<sup>5</sup> Plastic tubing with two prongs placed in the nostrils for delivery of supplemental oxygen.

At 6:20 a.m. the bedside sitter (for 1:1 observation) noticed that the patient was not breathing. Cardiopulmonary resuscitation was instituted immediately, and a Code Blue was called. Resuscitative efforts were unsuccessful, and the patient was pronounced dead at 7:30 a.m. An autopsy was performed, and the cause of death was described as “Probable spontaneous cardiac dysrhythmia, natural cause.”

## Findings

The VAMC has a Medical Emergency Response System for patients with signs of deterioration, but the System was not activated.

VAMC staff completed several reviews to assess the quality of care provided for this patient.

## Conclusions

We found the quality of care reviews conducted by the VAMC to be thorough.

We found deficiencies in the quality of care provided for this patient, but we did not demonstrate a connection with the patient’s death. A resident physician conducted an evaluation approximately 5 hours before the patient’s cardiopulmonary arrest, but the patient’s subsequent restlessness and hypoxemia should have prompted an assessment of underlying causes prior to administration of an intravenous (IV) sedative. The sedative and an IV narcotic were administered at reasonable doses, but this combination might best have been avoided during a pursuit of an explanation for this patient’s restlessness and hypoxemia. Although the VAMC has in place a procedure for the expeditious assessment of patients whose condition is worsening, physician and nursing personnel did not take advantage of this resource.

## Recommendations

**Recommendation 1.** We recommended that the VISN Director ensure that the Medical Center Director evaluates this case with Regional Counsel for possible disclosure to the patient’s family.

**Recommendation 2.** We recommended that the VISN Director ensure that the Medical Center Director requires that staff comply with the VAMC’s policy for rapid intervention in patients with deteriorating clinical conditions.

## Comments

The VISN Director and Medical Center Directors agreed with the findings and conclusions. (See Appendixes A and B for the Directors' comments.) Management submitted appropriate implementation plans; we will follow up until all actions are complete.

*(original signed by:)*

JOHN D. DAIGH, JR., M.D.  
Assistant Inspector General for  
Healthcare Inspections

## VISN Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** November 9, 2009

**From:** Director, VA Great Lakes Health Care System (10N12)

**Subject:** **Healthcare Inspection – Review of an Unexpected Death, North Chicago VA Medical Center, North Chicago, Illinois**

**To:** Director, Chicago and Kansas City Offices of Healthcare Inspections (54CH/KC)

Director, Management Review Service (10B5)

Attached please find the Review of an Unexpected Death draft response from North Chicago VA Medical Center.

I have reviewed the draft report for North Chicago VA Medical Center and concur with the findings and recommendations.

I appreciate the Office of Inspector General's efforts to ensure high quality care to veterans and the active duty patients and families at the North Chicago VAMC.



*for and in the absence of*

Jeffrey A. Murawsky, M.D.

## Medical Center Director Comments

**Department of  
Veterans Affairs**

**Memorandum**

**Date:** November 9, 2009

**From:** Director, North Chicago VA Medical Center (556/00)

**Subject:** **Healthcare Inspection – Review of an Unexpected Death, North Chicago VA Medical Center, North Chicago, Illinois**

**To:** Director, VA Great Lakes Health Care System (10N12)

I want to express my appreciation to the Office of Inspector General (OIG) for their professional and comprehensive review of an unexpected death here at the North Chicago VA Medical Center.

I have reviewed the draft report for the North Chicago VA Medical Center and concur with the findings and recommendations.

I appreciate the opportunity for this review as a continuing process to improve the care to our veterans and DoD patients.



Patrick L. Sullivan, FACHE



nurse (8/09). Additional education done for the entire nursing staff included review of the crash carts, MERS training and proper documentation (11/09).

To reinforce the process: the rapid response initiation criteria will be distributed to all inpatient clinical staff including residents and nursing areas. A refresher in-service will be provided to all inpatient units. A hospital-wide Grand Rounds on this topic will be scheduled.

## OIG Contact and Staff Acknowledgments

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OIG Contact	Jerome E. Herbers, Jr., MD (202) 461-4658
Acknowledgments	Paula Chapman, CTRS Verena Briley-Hudson, MN, RN Judy Brown, Program Assistant

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