Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Patient Neglect During a Magnetic Resonance Imaging Exam Michael E. DeBakey VA Medical Center Houston, TX

Report No. 08-01380-154 **June 27, 2008**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General, Office of Healthcare Inspections conducted an inspection in response to an allegation that a patient was neglected during a Magnetic Resonance Imaging (MRI) exam. The complainant specifically alleged that he did not feel there was staff present in the MRI suite since there was no response when he pushed the "panic button" and called for help during his MRI exam.

We did not substantiate the allegation that the patient was left unattended in the MRI suite during an exam; however, we concluded that the panic button was not working at the time of the incident, and even though the intercom was functional, the MRI technologist did not hear the patient call out for help. In a state of panic, the patient crawled out of the MRI machine without assistance. He was not injured during the incident. The patient returned the following day and completed the MRI.

At the time of the incident, there were no routine checks for functionality of the patient intercom system or panic button. The medical center has implemented a comprehensive system for assuring that patient safety and communication is maintained before and during an MRI test; therefore, we made no recommendations.

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

TO: Director , VA Heart of Texas Healthcare Network (10N17)

SUBJECT: Healthcare Inspection – Alleged Patient Neglect During an MRI Exam, Michael E. DeBakey VA Medical Center, Houston, TX

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections received a request from Congressman Ron Paul to conduct an inspection in response to an allegation that a patient was neglected during a Magnetic Resonance Imaging (MRI) exam. The purpose of the review was to determine whether the allegation had merit.

Background

The Michael E. DeBakey VA Medical Center (the medical center) is the primary and tertiary inpatient and outpatient healthcare service provider for more than 116,000 veterans in southeast Texas and is part of Veterans Integrated Service Network (VISN) 17.

The medical center provides comprehensive radiology services. MRI is a type of radiology exam that is often used in the diagnosis and/or treatment of neurological, musculoskeletal, cardiovascular, and oncological conditions. MRI exams typically require patients to lie perfectly still in a narrow MRI "tunnel" while detailed internal images of the targeted body part are captured digitally. MRI machines are noisy and confining, so patients are usually screened for claustrophobia[1] prior to the exam.

In late January 2008, the complainant contacted Congressman Ron Paul's office to report his dissatisfaction with a recent MRI exam. The complainant, who has a history of cervical spine disease, underwent an MRI on January 16, 2008, due to worsening neurological symptoms and pain. According to the medical record, the patient denied claustrophobia during a routine pre-MRI screening.

[1] Intolerance of confined spaces.

During the procedure, however, the patient became claustrophobic and pressed the panic button to alert the radiology staff that he wished to stop the procedure and be removed from the MRI machine. When there was no response from the staff, he yelled for help, but no one came to his aid. His claustrophobia worsened, so he crawled out of the MRI machine without assistance. At that time, a staff member entered the room. The patient was not injured during his exit from the machine. The patient returned the following day and completed the MRI exam without incident.

Scope and Methodology

We interviewed the patient by telephone on April 23, 2008. We interviewed the Medical Center Director, Diagnostic and Therapeutic Care Service Line Executive,[2] and the lead MRI technologist who cared for the patient on the day in question. In addition, we reviewed the patient's medical records, Service Line policies, the patient incident report, and staff meeting minutes detailing the event and corrective actions to be taken.

We conducted the inspection in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

While we did not substantiate the allegation that the patient was left unattended during an MRI exam, we confirmed that the panic button was not functional at the time of the incident. Immediately following the patient's complaint to the MRI technologist, radiology staff tested the panic button and confirmed that it was not working. Staff notified the MRI vendor and the panic button was repaired immediately. Radiology staff also found that the intercom system was functional; however, the technologist reported that he did not hear the patient call for him. We were told that technologists always turn the volume down in the control room[3] because an MRI in progress is loud.

We found that the MRI technologist was in the control room as his presence was required to operate the MRI machine. The MRI technologist told us that although he did not specifically recall the circumstances, he may have briefly stepped away from the control room window to assist another patient in the changing area. The control room window faces the MRI machine and the technologist had a view of the patient lying on the table. A camera mounted at the opposite end of the MRI machine displays a view of the patient's head on a video monitor in the control room. When he noticed the patient getting off the table, he immediately went into the room to assist. As the patient was already standing, the technologist reported that he assessed him for dizziness and pain.

[2] This individual has responsibility for Radiology Service.

[3] The control room is adjacent to the MRI exam room and contains the electronic equipment that runs the MRI machine.

Medical center managers subsequently took the following actions to ensure that all patient communication systems are operational prior to MRI exams:

- The March 19, 2008, Radiology Service meeting minutes reflect the following staff instructions: "QA [quality assurance] must include all patient communication systems. The tech [technologist] must communicate with patient periodically during the exam. Also observe the patient to make sure patient is not trying to come out of the Magnet due to any reason."

- Staff utilize a QA checklist that requires daily testing of the intercom, panic button, and MRI machine.

- The MRI safety policy was updated in April 2008 and includes the statement that "Patient will be instructed in the use of the panic button and voice-activated speaker prior to the beginning of the examination."

- The pre-MRI checklist was updated and now requires staff to explain the use of the panic button and intercom system to patients.

- A nurse pre-screens patients to identify safety and comfort concerns prior to their exams.

- The vendor provides regularly scheduled preventative maintenance on the MRI machine and the medical center is tracking the timeliness and completeness of the vendor's maintenance work.

Because staff cannot be directly at the patient's side during an exam for safety reasons, a functional intercom and panic button system, along with appropriate patient monitoring, is imperative for the safe and efficient completion of MRI exams.

Conclusions

We did not substantiate the allegation that the patient was left unattended in the MRI suite during an exam; however, we concluded that the panic button was not working at the time of the incident, and even though the intercom was functional, the MRI technologist did not hear the patient call out for help. In a state of panic, the patient crawled out of the MRI machine without assistance. He was not injured during the incident. The patient returned the following day and completed the MRI.

At the time of the incident, there were no routine checks for functionality of the patient intercom system or panic button. The medical center has implemented a comprehensive system for assuring that patient safety and communication is maintained before and during an MRI test. Because the medical center had already taken appropriate actions, we made no recommendations.

Comments

The VISN and Medical Center Directors agreed with our findings. No follow-up actions are planned.

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

OIG Contact and Staff Acknowledgments

OIG Contact	Carol Torczon, Associate Director St. Petersburg Office of Healthcare Inspections (727) 395-2409
Acknowledgments	Victoria Coates Andrea Buck, M.D.

Appendix B

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