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Healthcare Inspection - Patient Death Following Failure to Attempt Resuscitation, VA Ann Arbor Healthcare System Ann Arbor, Michigan
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[Mike] I'm Mike Nacincik, the OIG's public affairs officer, and your host for this episode.

We have with us Dr. Julie Kroviak, Deputy Assistant Inspector General for Healthcare Inspections, to talk about the OIG's *Healthcare Inspection - Patient Death Following Failure to Attempt Resuscitation.*

[Mike] Hi Dr. Kroviak, this is a report about the tragic death of a patient during an acute event at the Ann Arbor VA Healthcare System. Ultimately, the OIG found that the hospital staff acted on incorrect information regarding the resuscitation code status for this patient.

I wanted to talk with you today about what happened in this case and then have you speak a bit about whether the problems identified in the report have been resolved and if there are implications for other VA medical facilities.

[Dr. Kroviak] So simply put, this patient was admitted to the hospital. The medical record noted that this patient was a "FULL CODE." This means that in the event of a health emergency, when the patient can no longer communicate his or her wishes, medical staff should attempt all interventions for resuscitation. Unfortunately, this patient did suffer a serious health event and the staff on duty did not appropriately initiate potentially life-saving interventions, such as CPR, intubation, defibrillation, or specific medications. Basically staff mistakenly assumed this patient's code status was DNAR—or "do not attempt resuscitation" in the event life-saving measures are required.

[Mike] Tell me, from your perspective as a physician, why is this report important?

[Dr. Kroviak] Mike, this report is important because this type of confusion surrounding a patient's code status can lead to devastating consequences. This is an important issue in not just VA hospitals but also other government hospitals such as those administered by the Department of Defense and private hospitals. Additionally, since VA policies allow each of their medical centers to address the coordination of resuscitation codes individually it is important that each VA hospital has strong, effective policies regarding code status documentation.

[Mike] The report talks about "sentinel events." Can you explain what a sentinel event is and why healthcare facilities monitor these?

[Dr. Kroviak] So *sentinel* events are serious injuries or deaths that are not related to the patient's underlying illness. There are the thankfully uncommon examples of a patient who undergoes amputation of the incorrect limb, or a patient who accidentally receives medication intended for another patient, or more common, a patient receives medication for which they have a known allergy. Understanding exactly how they happened is critical to not repeating them. In this case, the sentinel event involved the miscommunication of a patient's code status.

[Mike] So how and why do these things happen in hospitals? These are places with highly trained medical experts.

[Dr. Kroviak] That's a complicated question. Research supports that a large percentage of these events are caused by human error. And even highly trained medical experts are human.

In the report we talk about three categories of human error: First, skill-based error—basically inattention and memory failure. In this case, a nurse was caring for three patients with varying needs, who was relying on her memory during a very stressful situation in which one of those patients coded.

Second, there are knowledge-based errors. These types of errors occur when the understanding of a given situation is fundamentally incomplete or flawed. We conducted several staff interviews and learned that all the staff believed they were honoring the patient's wishes, in fact they felt they had no reason to doubt the accuracy of what one nurse told them regarding the patient's code status. It was truly a case of "they didn't know what they didn't know."

Finally, communication and leadership errors can occur. The Veterans Health Administration (VHA) requires that end-of-life care be discussed with every patient admitted to a hospital. But beyond documenting the outcome of that conversation in the medical record, there is really no other guidance on how a patient's decision should be communicated to hospital personnel. VA facilities establish those mechanisms on their own. This facility's policy did not address specifically in the record where that information should be recorded, nor did they have a standardized process to ensure that every one caring for a patient was aware of the code status.

[Mike] Most people listening to this podcast have never worked in a hospital, and have not witnessed a "code." Television shows and movies are their only reference. Can you describe what really happens during an event like this?

[Dr. Kroviak] Well, let me first state that every situation is unique. In an ideal setting, all staff members assigned to a specific patient are well aware of the patient's diagnoses, treatment plan, and certainly code status. When a patient is noted to be in distress there is a policy in place that dictates how and when various staff members mobilize and intervene… a "trigger." For example, a patient is found unresponsive by her nurse. The nurse, aware of the patient's code status, starts the process—maybe that is an alarm button that signals a "code team" to rush to the patient's bedside and begin resuscitation efforts. In real life this looks like "organized chaos." It is a choreographed event with a fairly large cast of physicians, residents, nurses, respiratory therapists, maybe anesthesia staff, health techs, and others. Everyone has a role. Whoever is leading the code verifies with the nurse, treating provider, or medical record, the actual code status. Again, understand, these interventions are extremely time sensitive—seconds matter, and accuracy is critical.

[Mike] Okay, I'm envisioning a small room with a lot of medical professionals surrounding a hospital bed all shouting orders, drawing blood, chest compressions, beeping alarms; it seems pretty intense, actually frightening.

[Dr. Kroviak] Yes, intense, and yes often times crowded, but remember, I said "organized"? These are trained professionals, and while students may be observing as a teaching exercise, experienced providers are dictating the process. But as this report illustrates, hospitals still must plan carefully to decrease the room for human error during this "intense process" because despite the experience and skill of the staff, what matters is team members having accurate information about a patient.

[Mike] So, obviously the next questions is, what can a hospital do to prevent this type of error?

[Dr. Kroviak] Excellent and very difficult question. There are challenges with balancing patient safety and patient privacy. Does a wristband or bedside notice reveal too much personal patient information? What if during my hospital stay I change my mind? Maybe I have a conversation with a family member or Chaplain, or my doctor, and now I need "an updated bracelet." What if a step is missed and my new bracelet never makes it to my wrist?

This is not a problem unique to VA, and there is plenty of literature to support that many healthcare systems have struggled to eliminate such confusion. There may not be one approach that fits every healthcare facility. Regardless, facility clinicians, administrators, medical ethics specialists, and legal teams will need to

be part of these discussions and decisions.

[Mike] Is there a bottom line, what should we take away from this report, and what did the OIG recommend?

[Dr. Kroviak] What we point out in the report, in fact it is a recommendation, is that staff should be required to immediately verify the code status of the patient in distress without delaying resuscitative efforts. This particular facility reports that going forward the Charge Nurse or Nursing Supervisor will need to verify code status using the electronic medical record. This process will be recorded in a code debriefing, so the facility can monitor compliance.

[Mike] Dr. Kroviak, thank you.

[Dr. Kroviak] Thank you for the opportunity to talk about this important issue.

[Mike] Thanks for listening and stay tuned for our next podcast. The OIG podcast is produced by VA OIG staff and is available on the VA OIG's website.

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