



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

58

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Alleged Wrongful Death and
Deficiencies in
Documentation of a
Patient's Do Not Attempt
Resuscitation Status at the
Baltimore VA Medical
Center
Maryland



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an anonymous allegation that a patient “may have died wrongfully” by aspiration during resuscitation attempts, and that the patient had a Do Not Attempt Resuscitation (DNAR) order but resuscitation was attempted at the Baltimore VA Medical Center (facility), Maryland.¹

The OIG also identified the following concerns related to

- DNAR documentation and communication of the DNAR status,
- Facility leaders failed to follow up on a patient safety concern related to Parkinson’s medication contraindications, and
- Code blue documentation.

The OIG substantiated that the patient died due to aspiration pneumonia, and subsequent cardiopulmonary arrest, and that facility staff attempted resuscitation. The specific cause of the event leading to cardiopulmonary arrest could not be determined. Moreover, the death certificate identified the cause of death as aspiration pneumonia due to dysphagia and Parkinson’s disease.

The OIG was unable to determine whether the cause of death by aspiration pneumonia constituted a wrongful death, or that any action by facility staff contributed to the aspiration pneumonia.

The OIG found that during this episode of care, staff inaccurately documented that the patient missed a dose of a medication for Parkinson’s disease symptoms when in fact the patient received one additional dose. While this erroneous documentation may have influenced medication decisions and attempts to diagnose the patient’s altered mental status, the OIG team could not determine if the documentation inaccuracies contributed to any adverse clinical outcomes.

The OIG substantiated that facility staff attempted resuscitation on a patient with a DNAR status; however, there was no DNAR order in the electronic health record when resuscitation was attempted. The Intensive Care Unit attending physician reported speaking with the transferring medical team about the patient’s DNAR status but acknowledged the patient did not have the DNAR order. The physician acknowledged the medical team did not place the DNAR order upon admission to the Intensive Care Unit, nor through the time of the patient’s death.

¹ VHA Handbook 1004.04, *State-Authorized Portable Orders (SAPO)*, October 25, 2012. This handbook was rescinded on February 26, 2019. The handbook defines a DNAR (Do Not Attempt Resuscitation) order as, “an order instructing health care personnel to withhold CPR in the event of cardiac arrest. [T]he terms DNR, No-CPR, and No Code are synonymous with DNAR. DNAR is the preferred term in VHA.”

The OIG determined that residents and attending physicians did not comply with documentation requirements for DNAR orders and DNAR progress notes and failed to effectively communicate the DNAR status to all appropriate healthcare team members.

The OIG found that residents and attending physicians failed to write either a DNAR order or progress note on admission and failed to rewrite DNAR orders upon the patient's transfer from one unit to another. The OIG determined that residents and attending physicians wrote full code orders in telemetry order sets, directing staff to initiate cardiopulmonary resuscitation; however, these orders directly conflicted with the DNAR status documented in resident and attending physicians' progress notes.

The OIG determined that attending physicians failed to effectively communicate the patient's DNAR status to the nursing staff. The OIG found that the absence of physician DNAR orders and progress notes, the presence of contradictory full code orders in the telemetry order sets, and the lack of effective physician communication to the nursing staff resulted in the patient's healthcare team not having the correct information needed to appropriately intervene when the patient became unresponsive.

The OIG found a pharmacy systems issue identified in Executive Committee of the Medical Staff meeting minutes that facility leaders and managers failed to take action on and monitor through completion. Specifically, the early fall 2018 meeting minutes identified a patient safety issue related to the administration of haloperidol in patients with Parkinson's and tasked the issue to the Pharmacy and Therapeutics Committee for action.² The issue was closed without action in late fall 2018 due to lack of administrative oversight, and was not fully addressed until the OIG requested a status update in February 2019.

The OIG found facility staff did not comply with Veterans Health Administration policy regarding code blue documentation, including the required Code Blue/Rapid Response provider and nursing note and the Code Blue/Rapid Response Critique note. The OIG determined that the facility's existing measures to identify challenges with resuscitation processes and develop strategies and actions for improvement were insufficient. The OIG found that the Chief of Staff and Associate Director for Patient Care Services failed to hold clinical staff responsible for code blue documentation.

The OIG made recommendations related to the facility leaders' review of the patient's course of treatment; the identification, documentation, and communication of patients' DNAR; tracking, documenting, and completing action items in the Executive Committee of the Medical Staff; and tracking code blue/rapid response events.

² Haloperidol is a type of antipsychotic medication typically used to treat psychotic disorders. Mayo Clinic, *Haloperidol*, 2019. <https://www.mayoclinic.org/drugs-supplements/haloperidol-oral-route/description/drg-20064173>. (The website was accessed on March 13, 2019.)

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan. (See appendixes B and C, pages 27–30, for the Directors' comments.) The OIG considers all recommendations open and will follow up on the planned actions until they are completed.



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Abbreviations

ADPCS	Associate Director of Patient Care Services
ACLS	advanced cardiac life support
CPR	cardiopulmonary resuscitation
DNAR	do not attempt resuscitation
DNI	do not intubate
ECMS	Executive Committee of the Medical Staff
EHR	electronic health record
ICU	Intensive Care Unit
NMS	neuroleptic malignant syndrome
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to an anonymous allegation that a patient “may have died wrongfully” by aspiration during resuscitation attempts, and that the patient had a Do Not Attempt Resuscitation (DNAR) order but resuscitation was attempted at the Baltimore VA Medical Center (facility), Maryland.³

Background

The facility is part of the VA Maryland Health Care System (system) which includes the Loch Raven and Perry Point VA Medical Centers, and six community based outpatient clinics.⁴ The system is aligned under Veterans Integrated Service Network (VISN) 5. The facility is an acute medical and surgical care facility and offers a full range of inpatient, outpatient, and primary care services. VA classifies the facility as a Level 1b–High Complexity facility.⁵ In fiscal year 2018, the facility served 53,685 patients and had a total of 591 hospital operating beds, including 142 inpatient beds, 163 domiciliary beds, 263 community living center beds, and 23 Compensated Work Therapy/Transitional Residence beds. The facility is affiliated with the University of Maryland School of Medicine and other local colleges and universities. Over 1,100 residents, interns, and students are trained throughout the facility each year.⁶

³ VHA Handbook 1004.04, *State-Authorized Portable Orders (SAPO)*, October 25, 2012. This handbook was rescinded on February 26, 2019. The handbook defines a DNAR order as, “an order instructing health care personnel to withhold CPR in the event of cardiac arrest. [T]he terms DNR, No-CPR, and No Code are synonymous with DNAR. DNAR is the preferred term in VHA.”

⁴ The system’s community based outpatient clinics include: Cambridge VA Outpatient Clinic; Eastern Baltimore County VA Outpatient Clinic; Fort Meade VA Outpatient Clinic; Glen Burnie VA Outpatient Clinic; Loch Raven VA Outpatient Clinic; and Pocomoke City VA Outpatient Clinic.

⁵ The VHA Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3, with Level 1a facilities being the most complex and Level 3 facilities being the least complex. VHA Office of Productivity, Efficiency and Staffing. (The website was accessed on August 14, 2019 and is an internal VA website not publicly accessible.)

⁶ VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012. This VHA Handbook was scheduled for recertification on or before the last working day of December 2017, but has not been recertified. The handbook defines a resident as “an individual who is engaged in an accredited graduate training program for physicians, dentists, optometrists, and podiatrists, and who participates in patient care under the direction of supervising practitioners.”

Parkinson's Disease

Parkinson's disease is a chronic, progressive disease that affects the nervous system with diverse clinical features including motor, non-motor, and neuropsychiatric manifestations.⁷ Symptoms may include tremors, slowed movement, and muscle rigidity, that may cause difficulty walking or completing simple daily tasks. Due to the chronicity of Parkinson's, treatment focus includes symptom control and lifestyle changes to promote maximized function.⁸ The American Parkinson's Disease Association estimates one million American's are living with Parkinson's.⁹

Medications and Side Effects

Medications for Parkinson's target dopamine receptors to control movement and other symptoms. Levodopa is the mainstay treatment for Parkinson's symptoms; however, side effects of the medication include nausea, vomiting, and low blood pressure when standing from a sitting or lying down position.¹⁰ Often patients with Parkinson's receive a combination of carbidopa-levodopa, to limit the side effects of levodopa when used alone.¹¹ Another commonly used medication to treat the symptoms of Parkinson's is amantadine, which treats sudden uncontrolled muscle movements.¹²

Antipsychotics

Psychosis, particularly visual hallucinations, occurs in up to 40 percent of patients with Parkinson's, and may require antipsychotic medications; however, some antipsychotic medications can also affect the dopamine levels in the brain and can cause or worsen Parkinson's

⁷ S. Sveinbjornsdottir, "The Clinical Symptoms of Parkinson's Disease," *Journal of Neurochemistry*, 2016, 139, (Suppl. 1) Pages 318-324, <https://www.ncbi.nlm.nih.gov/pubmed/27401947>. (The website was accessed on March 25, 2019.) The Mayo Clinic, *Parkinson's Disease*, 2019. <https://www.mayoclinic.org/diseases-conditions/parkinsons-disease/symptoms-causes/syc-20376055>. (The website was accessed on March 11, 2019.)

⁸ The Mayo Clinic, *Parkinson's Disease*, 2019. <https://www.mayoclinic.org/diseases-conditions/parkinsons-disease/symptoms-causes/syc-20376055>. (The website was accessed on March 11, 2019.)

⁹ American Parkinson's Disease Association, *What is Parkinson's Disease*, March 2019. <https://www.apdaparkinson.org/what-is-parkinsons/>. (The website was accessed on March 11, 2019.)

¹⁰ C. Olanow, C. Klein, A.V. Schapira. Parkinson's Disease. In: Jameson J, Fauci AS, Kasper DL, Hauser SL, Longo DL, Loscalzo J., eds. *Harrison's Principles of Internal Medicine*, 20th ed. (New York, NY: McGraw-Hill). <http://accessmedicine.mhmedical.com/content.aspx?bookid=2129§ionid=192532363>. (The website was accessed on March 11, 2019.) The Mayo Clinic, *Parkinson's Disease*, 2019. <https://www.mayoclinic.org/diseases-conditions/parkinsons-disease/diagnosis-treatment/drc-20376062>. (The website was accessed on March 11, 2019.)

¹¹ The Mayo Clinic, *Carbidopa and Levodopa*, 2019. <https://www.mayoclinic.org/drugs-supplements/carbidopa-and-levodopa-oral-route/description/drg-20095211>. (The website was accessed on March 15, 2019.)

¹² Amantadine is an anti-Parkinson agent used to treat dyskinesia. The Mayo Clinic, *Amantadine*, 2019. <https://www.mayoclinic.org/drugs-supplements/amantadine-oral-route/description/drg-20061695>. (The website was accessed on March 13, 2019.)

symptoms.¹³ Haloperidol, is a type of antipsychotic medication.¹⁴ While not prohibited, haloperidol use in patients with Parkinson's is contraindicated and can cause a potentially fatal reaction, known as neuroleptic malignant syndrome (NMS).¹⁵

NMS is an adverse reaction to medications that interfere with the dopamine biochemical pathway. These include antipsychotics or nausea medications or withdrawal of Parkinson's medications. Although NMS occurs rarely, there is a 10–30 percent risk of death and is considered a neurologic emergency. Patients typically develop rigid muscles, fever, high heart rate and blood pressure, confusion, and swallowing difficulties.¹⁶

Complications of Parkinson's

Dysphagia, difficulty swallowing, is a condition often caused by neurological disorders such as Parkinson's and can include drooling, inability to swallow, and coughing or gagging.¹⁷ Over 80 percent of patients with Parkinson's experience dysphagia as part of the disease process.¹⁸

Drooling can lead to eating and speaking difficulties and can cause a "silent aspiration of saliva" into the airway.¹⁹ Drooling is a predictor of dysphagia and aspiration pneumonia in patients with Parkinson's.²⁰

Speech-language pathologists, also called speech therapists, provide therapy to patients with Parkinson's to address the effects of dysphagia and reduce the risk of malnutrition and aspiration pneumonia.²¹

¹³ Psychosis is a "loss of contact with reality" characterized by hallucinations, apathy, and a slowing of speech, motor activity and mental functioning. Mehrul, Hasnain, et al., "Pharmacological Management of Psychosis in Elderly Patients with Parkinsonism," *American Journal of Medicine*, 2009-07-01, Volume 122, Issue 7, Pages 614-622.

¹⁴ Mayo Clinic. *Haloperidol*, 2019. <https://www.mayoclinic.org/drugs-supplements/haloperidol-oral-route/description/drg-20064173>. (The website was accessed on March 13, 2019.)

¹⁵ Brian D. Berman, "Neuroleptic Malignant Syndrome: A Review for Neurohospitalists," *The Neurohospitalist*, 1(1) 41-47(2011).

¹⁶ Berman, "Neuroleptic Malignant Syndrome."

¹⁷ Mayo Clinic, *Dysphagia*, <https://www.mayoclinic.org/diseases-conditions/dysphagia/symptoms-causes/syc-20372028>. (The website was accessed on March 14, 2019.)

¹⁸ Inga Suttrup and Tobias Warnecke, "Dysphagia in Parkinson's Disease," *Dysphagia*, 31:24–32, (2016.)

¹⁹ Prachaya Srivanitchapoom, Sanjay Pandey, and Mark Hallett "Drooling in Parkinson's Disease: A Review," *Parkinsonism Relat Disord*. 2014 November; 20(11): 1109–1118.

²⁰ Inga Suttrup and Tobias Warnecke, "Dysphagia in Parkinson's Disease."

²¹ VHA Handbook, 1170.02(1), *VHA Audiology and Speech-Language Pathology Services*, March 14, 2011. This Handbook was scheduled for re-certification on or before the last working day of March 2016, but has not been recertified. (Amended January 30, 2019, to clarify role of Audiology health technician.) A speech-language pathologist is a credentialed clinician who provides services related to "the identification, evaluation, diagnosis, and treatment of persons with speech, voice, language, fluency, cognitive, swallowing, and respiratory disorders".

A common dysphagia evaluation procedure is the modified barium swallow.²² The modified barium swallow is an imaging procedure where an x-ray is taken while the patient swallows different types of liquids and solids. This allows the radiologist and speech-language pathologist to study how a patient swallows food and may help identify the reason a patient may aspirate.²³

Aspiration Pneumonia

Aspiration pneumonia is a major cause of death for the Parkinson's disease patient population.²⁴ In aspiration pneumonia, large volumes of food or other material from the mouth or stomach enter the airway and bacterial growth alters lung function. It is often difficult to identify when a patient may have aspirated, as the event is not always witnessed, and symptoms tend to develop within a few hours to a few days. Symptoms of aspiration pneumonia may be a cough or as severe as respiratory failure.²⁵

Prior OIG Reports

The OIG conducted a search and found one report pertaining to the facility with the same or similar topics published within the last three years.

A February 23, 2016, OIG report, *Combined Assessment Program Review of the VA Maryland Health Care System, Baltimore, Maryland*, (Report No. 15-05497-132), determined the facility did not document that employees asked inpatients whether they wished to discuss creating, changing, and/or revoking advance directives and had not scanned the most current advance directive into patient electronic health records (EHR).²⁶ Two of the 26 closed recommendations addressed an issue relevant to the current OIG report:

- The OIG recommended that employees consistently scan the most current advance directive into the EHR and that facility managers monitor compliance.

²² University of Maryland Baltimore Washington Medical Center, *Modified Barium Swallow*, <https://www.umms.org/bwmc/health-services/rehabilitation/speech-language-pathology/modified-barium-swallow>. (The website was accessed on December 31, 2018.)

²³ University of Maryland Baltimore Washington Medical Center, *Modified Barium Swallow*.

²⁴ Aspiration pneumonia is a swelling or infection of the lungs when food or liquid is inhaled into the lungs. <https://medlineplus.gov/ency/article/000121.htm>. (The website was accessed on March 13, 2019.); Inga Suttrup and Tobias Warnecke, "Dysphagia in Parkinson's Disease," *Dysphagia*, 31:24–32, (2016).

²⁵ Lionel A. Mandell, Michael S. Niederman, "Aspiration Pneumonia," *N Engl J Med*, 2019; 380:651-63.

²⁶ VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*. This VHA Handbook was scheduled for recertification on or before the last working day of December 2018, but has not been recertified. An advance directive is a written statement of these preferences by the patient with decision-making capacity. Decision-making capacity is a clinical judgment about a patient's ability to make health care decisions. VAOIG, Office of Health Care Inspection, *Combined Assessment Program Review of the VA Maryland Health Care System, Baltimore, Maryland*, Report Number 15-05497-132, published February 23, 2016. Retrieved from www.va.gov/oig/oig.gov.

- The OIG recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.

Allegations and Related Concerns

On October 10, 2018, the OIG received an anonymous complaint alleging that a patient “may have died wrongfully” by aspiration during resuscitation attempts at the facility in the fall of 2017. The complainant also reported that the patient had a DNAR order, but the facility staff attempted resuscitation.

The OIG identified the following concerns related to

- DNAR documentation and communication of the DNAR status,
- Facility leaders failed to follow up on a patient safety concern related to Parkinson’s medication contraindications, and
- Code blue documentation.²⁷

Scope and Methodology

The OIG initiated the inspection on November 19, 2018, and conducted a site visit from January 23–24, 2019. A second site visit was conducted on February 6, 2019.

The OIG reviewed Veterans Health Administration (VHA) and facility policies related to advance directives, adverse drug events reporting, DNAR orders and documentation, handoff communication, clinical and institutional disclosures, cardiopulmonary resuscitation (CPR), code blue and medical emergency response, inpatient medication orders, medication storage, life-sustaining treatment, resident supervision, patient transfer and referral, pharmacy and staffing practices, quality management, performance improvement, and peer review.²⁸

Because the OIG team was unable to determine the anonymous complainant’s understanding of how the patient may have “died wrongfully,” the OIG reviewed the patient’s episode of care,

²⁷ Facility Policy 115/ACCC-004, *Code Blue/Rapid Response*, February 2016; Facility Policy 512-11 COS-036, *Medical Emergency Response Teams*, January 2015. A code blue is an alert called in the event of a cardiopulmonary arrest, and where a designated team of medical staff provide an emergency response. Within the context of this report, the term “facility policy” refers to policies issued by VA Maryland Health Care System.

²⁸ Facility Policy 512-00/PS-012, *Do Not Attempt Resuscitation (DNAR) and State Authorized Portable Orders/Maryland Medical Orders for Life-Sustaining Treatment (SAPO/MOLST)*, September 2017; Facility Policy 512-122/SW-009, *Advance Directive*, March 2016. A life-sustaining treatment is “a medical treatment that is administered in an attempt to prolong the life of a Veteran who would be expected to die soon without the treatment.” Treatments may include “resuscitation, nutrition and hydration by feeding tube or intravenously, mechanical ventilation, antibiotics, blood transfusions, and dialysis.”

including the development of aspiration pneumonia and NMS-like symptoms, the clinical staff's management of dysphagia, and medication administration.

The OIG also reviewed relevant committee meeting minutes from the Critical Care Committee, Executive Committee of the Medical Staff, Executive Committee of the Governing Board, Executive Performance Improvement Committee, Nurse Practice Council, Peer Review Committee, and the CPR Committee. In addition, the OIG team conducted an empirical literature review of topics related to this inspection.

In January 2017, VHA issued a new life-sustaining treatment policy and allowed facilities 18 months to implement the new policy.²⁹ Because the new policy addressed some concerns identified by the OIG team pertaining to DNAR documentation, the scope of the inspection was expanded to include a review of the implementation of the new life-sustaining treatment orders (DNAR orders) and related progress note templates.³⁰

The OIG conducted interviews with facility leaders and employees familiar with the patient's care, including the: Chief of Staff; Associate Director of Patient Care Services (ADPCS); Chief of Quality; Performance Improvement, and Accreditations Director; Clinical Informatics/Clinical Applications Coordinator; Director of Patient Safety, Risk Management, and Infection Control; Chief of Pharmacy; Medicine and Intensive Care Unit (ICU) staff (four physician residents, three nurses, a physician, and a physical therapist); two certified registered nurse anesthetists; two performance improvement nurses; a clinical pharmacist; speech pathologist; risk manager; nurse educator; Life-Sustaining Treatment Decisions Initiative Committee Co-Chairs; and CPR Committee Co-Chairs.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take

²⁹ VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017. This Handbook rescinded and replaced VHA Handbook 1004.3, *Do Not Resuscitate (DNR) Protocols Within the Department of Veterans Affairs (VA)*, October 24, 2002.

³⁰ Crosswalk - VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, March 30, 2017. <https://www.ethics.va.gov/LST/PolicyChanges.pdf>. (The website was accessed on December 11, 2018.) Key policy changes relevant to this inspection included expanding the authority to write life-sustaining treatment orders (DNAR orders) to physician residents without requiring the attending physician's co-signature, prominently displaying these orders in the patient's EHR, and ensuring the DNAR orders do not expire or automatically discontinue based on dates, timeframes, or patient movements (admission, transfer to another level of care).

place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

The OIG conducted the inspection in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Patient Case Summary

The patient, in their 60s, with Parkinson's, tardive dyskinesia, heart disease, high blood pressure, bipolar disorder, and frequent falls.³¹

In 2015, the patient was admitted to the facility after presenting to the Emergency Department with food stuck in the esophagus. The patient underwent a swallow evaluation, which showed the patient was safe eating a pureed diet with thin liquids. A speech pathologist performed a follow-up swallow study in fall 2015, and recommended a mechanical diet consisting of chopped foods and thin liquids. The EHR had no further documentation about the patient's swallowing difficulties until summer 2017 when, in preparation for a gastrointestinal scope procedure, a nurse practitioner who performed the pre-operative History and Physical documented "dysphagia to solids multiple times a week."

In fall 2017, the patient presented to the facility's Neurology Clinic complaining that the Parkinson's medication carbidopa-levodopa was not very effective. The neurologist increased the dose of another medication (amantadine) to help control the patient's tremors.

A few weeks later, the patient presented to the facility's Emergency Department complaining of weakness after passing out two days earlier. The medicine resident (Resident 1) admitted the patient to a telemetry monitored bed on a medical unit to evaluate why the patient lost consciousness.³² In the admission note, Resident 1 documented that the patient wished not to be resuscitated in the event of a cardiac arrest, and that there was an advance directive on file from 2008. Resident 1 placed admission orders, one of which stated in the event that the patient lost their pulse, nurses were to start CPR; no DNAR order was entered.

The patient was transferred multiple times throughout the hospital admission including five transfers between the medical units and the ICU. (See appendix A for transfer chronology.) On hospital day 1, the patient was transferred to a medical unit that did not provide telemetry

³¹ The OIG uses the singular form of they (their/them) to protect the patient's privacy. Tardive dyskinesia is a potential side effect of long-term use dopamine medications such as levodopa and includes involuntary loss of control of muscles and repetitive body movements including: tongue jetting out, puckering and pursing lips, lip smacking, grimacing and eye blinking, and jerking movements of the arms and legs. V. Vijayakumar and J. Jankovic, "Drug-Induced Dyskinesia, Part 2: Treatment of Tardive Dyskinesia," *Drugs*, 76(7). 779-787 (2016.)

³² Telemetry is "a portable device that continuously monitors patient ECG, respiratory rate and/or oxygen saturations while automatically transmitting information to a central monitor."
https://www.rch.org.au/rchcpg/hospital_clinical_guideline_index/Cardiac_Telemetry/. (The website was accessed on April 3, 2019.)

monitoring, although there were telemetry orders in the EHR. The facility had a telemetry order set, which included the order for advanced cardiac life support (ACLS) and full code status.³³

Shortly thereafter, the patient was transferred to the ICU to be placed on telemetry monitoring. The ICU admission orders also stated that if the patient lost their pulse, nurses were to start CPR; again, no DNAR order was written.

A second neurologist and a neurology resident evaluated the patient and determined that the recent increase in dosing of amantadine likely contributed to the patient's loss of consciousness. The amantadine dosing schedule was then changed from 100 milligrams three times per day, to two times per day.³⁴

On hospital day 3, the patient was transferred to a medical unit when telemetry monitoring was no longer required. Overnight, the patient became increasingly agitated and confused, requiring physical restraints. Resident 2 ordered two milligrams of haloperidol intravenously for sedation. However, the patient's confusion worsened, and the patient developed a fever. On hospital day 4, Resident 3 and the medicine attending physician identified NMS as a possible cause of the patient's change in condition and transferred the patient to the ICU for an increased level of care.

On hospital day 7, the patient was transferred back to the medicine unit. The physical therapist recommended discharging the patient to a subacute rehabilitation facility. On hospital day 9, while waiting for placement, the patient developed a fever and cough. Resident 3 ordered a chest x-ray to check for pneumonia, and the results indicated "[a]telectasis is noted lung bases.³⁵ Increasing densities noted in the right perihilar region, concerning for infectious process." On hospital day 10, Resident 3 noted the patient had improved and inaccurately noted that the chest x-ray was "unremarkable." By the evening of hospital day 10, the patient required increasing amounts of oxygen for breathing. Resident 4 prescribed two types of antibiotics and initiated a

³³ Order sets are collections of related orders. Department of Veterans Affairs, Office of Information & Technology (OI&T), Enterprise Management Program Office (EMPO), Computerized Patient Record System (CPRS) User Guide: GUI Version, January 2019. Facility Policy 512-11-COS-038, *Staff Training in Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS)*, January 2015. Updated and replaced by Facility Policy 512-11-COS-038, *Cardiopulmonary Resuscitation*, November 2018. ACLS is "a set of life-saving protocols and skills that extend Basic Life Support (BLS) to further support the circulation and provide an open airway and adequate ventilation (breathing)." American Medical Association, "Why Not a Slow Code?" *Journal of Ethics*, 2012. <https://journalofethics.ama-assn.org/article/why-not-slow-code/2012-10>. (The website was accessed on May 30, 2019.) "A full code or code blue involves calling a rapid response team and initiating appropriate treatment as quickly and effectively as possible with the goal of reversing an adverse event..."

³⁴ Amantadine is an anti-Parkinson agent used to treat dyskinesia. The Mayo Clinic, *Amantadine*, 2019. <https://www.mayoclinic.org/drugs-supplements/amantadine-oral-route/description/drg-20061695>. (The website was accessed on March 13, 2019.)

³⁵ Atelectasis is the "collapse of the expanded lung." <https://www.merriam-webster.com/dictionary/atelectasis>. (The website was accessed on May 23, 2019.)

transfer back to the ICU, which occurred in the early morning hours of hospital day 11. The ICU admission orders stated that in case the patient lost their pulse, nurses were to start CPR.

The ICU resident (Resident 5) thought that the patient's symptoms were due to aspiration of stomach contents into the lungs and ordered a modified barium swallow evaluation.³⁶ On the morning of hospital day 11, the speech pathologist evaluated the patient and found that the patient was unable to safely swallow, and recommended a modified barium swallow for further evaluation. The ICU registered nurse escorted the patient to the Radiology Department in the afternoon. However, the patient was too agitated to sit in the exam chair, and the test was aborted before the patient received any barium contrast. The nurse was contacted to transfer the patient back to the ICU. On the nurse's arrival, the patient appeared calm and was breathing slowly.

During transfer to the ICU, the patient became unresponsive while in the elevator. Upon arrival back in the ICU, the nurse called a code blue and initiated CPR. The patient's ICU attending physician arrived and canceled the code blue, and resuscitation attempts were stopped at 2:30 p.m. The ICU physician declared the patient deceased, and at 2:46 p.m. entered the only DNAR order during the patient's hospitalization. The patient's death certificate listed the cause of death as aspiration pneumonia, due to dysphagia and Parkinson's.

³⁶ Modified barium swallow is a procedure where a patient swallows barium contrast and the radiologist takes x-ray pictures to view the progressive movement of the contrast material. UM Baltimore Washington Medical Center, *Modified Barium Swallow*, <https://www.umms.org/bwmc/health-services/rehabilitation/speech-language-pathology/>. (The website was accessed on February 20, 2019.) VHA Directive 1171, *Management of Patients with Swallowing (Oropharyngeal Dysphagia) and Feeding Disorders*, April 14, 2017.

Inspection Results

1. Allegation: A Patient May Have Died Wrongfully, by Aspiration, During Resuscitation Attempts

The OIG substantiated that the patient died due to aspiration pneumonia and subsequent cardiopulmonary arrest, and that facility staff attempted resuscitation. The specific medical event that led to cardiopulmonary arrest could not be determined. Moreover, the death certificate identified the cause of death as aspiration pneumonia due to dysphagia and Parkinson's.

The OIG evaluated the patient's care, including the development of aspiration pneumonia and NMS-like symptoms, the clinical staff's management of dysphagia, and medication administration.

Aspiration Pneumonia

The OIG team reviewed the patient's EHR and found no final diagnosis of NMS. A pulmonology fellow documented that a "NMS-like syndrome" had resolved. However, the development of NMS-like symptoms could have placed the patient at an increased risk for aspiration due to swallowing difficulties.³⁷ On hospital day 4, the patient's medical team transferred the patient to the ICU due to the patient's acute altered mental status and to determine if the patient's symptoms were related to NMS or other medical issues such as an infection. On hospital day 5, while the patient was in the ICU, the dietician ordered a mechanical diet. On hospital day 7, the patient improved and was transferred back to the medicine unit. Resident 3 told the OIG team "[w]e didn't have any concerns about [*sic*] swallow while on the floor [medical unit]." On hospital day 11, the patient was transferred back to the ICU because the patient developed aspiration pneumonia, and Resident 5 ordered that the patient not receive anything by mouth pending a speech pathology evaluation. The speech pathologist performed a bedside swallow test using honey thickened liquid and applesauce (to reduce risk of aspiration), noted dysphagia, and recommended a more advanced swallow assessment.³⁸

The OIG team reviewed the EHR and found that from hospital day 5, until the patient was kept without oral intake on the day the patient died, there was no documentation that the patient showed any signs of, or complained about, swallowing difficulties.

The ICU attending physician told the OIG team that, consistent with Parkinson's, the cause of the upper respiratory symptoms was likely aspiration, the patient had end stage Parkinson's, and

³⁷ Berman, "Neuroleptic Malignant Syndrome."

³⁸ See Patient Summary. The modified barium swallow test is the more advanced test unsuccessfully attempted just prior to the patient's death.

“an AD [advance directive] limiting tube feed. Not a whole lot we could do to prevent aspiration.”³⁹

The OIG was unable to determine whether the death by aspiration pneumonia constituted a “wrongful” death, or that actions by facility staff contributed to the aspiration pneumonia.

Medication Administration and Documentation

The OIG team reviewed the EHR and found the medical staff repeatedly documented that the patient missed a scheduled dose of carbidopa-levodopa at 8:00 p.m. on hospital day 3, potentially causing increased agitation and altered mental status. However, the OIG team reviewed the patient’s EHR and medication administration logs and found that the patient did not miss a dose of carbidopa-levodopa, but received an additional dose on hospital day 3, receiving five doses rather than four doses. A neurology resident changed the medication administration times of carbidopa-levodopa on hospital day 3, at 10:26 a.m., which resulted in the additional dose of carbidopa-levodopa.⁴⁰

VHA requires that a clinical pharmacist review all inpatient medication orders and verify the medication, current diagnosis, and indication for use.⁴¹ Facility policy requires the inpatient pharmacist to determine whether the patient has any identified allergies or adverse reactions and ensure there are no contraindications for the ordered medication.⁴² The pharmacist may use a flag (alert) in the EHR to return incomplete or questionable orders back to the ordering provider.⁴³ Additionally the pharmacist “will make every attempt to contact prescriber” to clarify an incomplete or questionable order.⁴⁴

Resident 2 ordered the haloperidol on hospital day 3, at 11:56 p.m. to be given immediately due to the patient’s increased agitation. Within an hour of the order the patient received a two-milligram intramuscular dose of haloperidol. A pharmacy alert on the order noted a significant drug to drug interaction with the administration of haloperidol and carbidopa-levodopa. Resident

³⁹ S. Varanese, Z. Birnbaum, R. Rossi, and A. Di Rocco, “Treatment of Advanced Parkinson's Disease,” *Parkinsons Dis* (February 7, 2011): 480260. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3038575/>. (The website was accessed on May 1, 2019.) Facility Policy 512-00/PS-012. An end stage condition is “An advanced, progressive, irreversible condition caused by injury, disease, or illness that has caused severe and permanent deterioration that may be indicated by incompetence and or complete physical dependency; and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective (e.g., Alzheimer's, multiple Cerebral Vascular Accidents, degenerative diseases which have progressed to end stage).”

⁴⁰ The original order scheduled doses of carbidopa-levodopa at 6:00 a.m., 10:00 a.m., 2:00 p.m., and 6:00 p.m. The dosing schedule change at 10:26 a.m. ordered doses at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. The patient received carbidopa-levodopa at 6:00 a.m., 10:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m.

⁴¹ VHA Directive 1108.06, *Inpatient Pharmacy Services*, February 8, 2017.

⁴² Facility Policy 512-119-015, *Inpatient Medication Orders*, August 2016.

⁴³ Facility Policy 512-119-015.

⁴⁴ Facility Policy 512-119-015.

2 documented “indicated” as an override reason for the medication administration in the EHR, and a pharmacist verified the order. When the pharmacist who verified the haloperidol was interviewed by the OIG, the interviewee indicated that the haloperidol was likely verified because of the low dose. Upon further questioning about the potential impact of haloperidol on a patient with Parkinson's, the pharmacist stated the information would have to be verified in the system. The Chief of Pharmacy stated that in retrospect, the patient should not have received the haloperidol. The Chief of Pharmacy later noted that most pharmacists would probably approve the haloperidol order because the ordering resident wrote “indicated” to override the drug to drug contraindication alert.

On hospital day 4, due to the patient's acute mental status change, the medical team transferred the patient back to the ICU to evaluate the cause of the decompensation (NMS or other condition). Resident 6 documented a concern for possible carbidopa-levodopa withdrawal, because the patient may have missed an evening dose of carbidopa-levodopa and developed parkinsonism-hyperpyrexia syndrome.⁴⁵ Further, multiple providers documented a missed carbidopa-levodopa dose.⁴⁶ Resident 6 documented possible causes of the patient's altered mental status including “NMS, acute dystonic reaction, metabolic process, carbidopa-levodopa withdrawal, and parkinsonism-hyperpyrexia syndrome” and related the change to the missed carbidopa-levodopa dose and the administration of haloperidol in a Parkinson's patient.⁴⁷ However, the OIG determined through EHR review the patient did not miss a dose of carbidopa-levodopa on hospital day 3, but received an additional dose due to a dosing schedule change.

During this episode of care, staff inaccurately documented that the patient missed a dose of carbidopa-levodopa when in fact the patient received one additional dose on hospital day 3. This erroneous documentation may have influenced medication decisions, such as the administration of haloperidol, and attempts to diagnose the patient's altered mental status. The OIG team could not determine if the documentation inaccuracies contributed to any adverse clinical outcomes.

⁴⁵ “Parkinsonism-Hyperpyrexia Syndrome is a rare but potentially fatal complication seen in patients with Parkinson's, most commonly following reduction or cessation of antiparkinsonian medications and clinically resembles neuroleptic malignant syndrome with rigidity, pyrexia, and reduced conscious.” E.J. Newman, D.G. Newman, & P. Kennedy, The Parkinsonism-Hyperpyrexia syndrome, *Neurocritical Care*, February 2009. <https://www.ncbi.nlm.nih.gov/pubmed/18712508>. (The website was accessed on March 20, 2019.)

⁴⁶ Four residents, a physician, a neurologist, a pulmonary fellow, and a pulmonologist.

⁴⁷ “Dystonia is a movement disorder in which your muscles contract involuntarily, causing repetitive or twisting movements.” Mayo Clinic, Dystonia, 2019. <https://www.mayoclinic.org/diseases-conditions/dystonia/symptoms-causes/syc-20350480>. (The website was accessed on April 30, 2019.) “Metabolic syndrome is a cluster of conditions that occur together, increasing your risk of heart disease, stroke and type 2 diabetes. These conditions include increased blood pressure, high blood sugar, excess body fat around the waist, and abnormal cholesterol or triglyceride levels.” Mayo Clinic, *Metabolic Syndrome*, 2019. <https://www.mayoclinic.org/diseases-conditions/metabolic-syndrome/symptoms-causes/syc-20351916> (The website was accessed on April 30, 2019.)

2. Allegation: Resuscitation Was Attempted on a Patient with a DNAR Order

The OIG substantiated that facility staff attempted resuscitation on a patient with a DNAR status; however, the OIG found that there was no DNAR order in the EHR when resuscitation was attempted.

On hospital day 10, the night before the code event, Resident 4 determined the patient needed a higher level of care due to increased oxygen requirements and transferred the patient to the ICU. At the time of transfer the patient did not have a DNAR order, and upon admission to the ICU, Resident 1 completed an emergency telemetry order with instructions to call a code blue and begin CPR if the patient had no pulse. On hospital day 11, the patient became unresponsive during transport from the Radiology Department. The ICU nurse called a code and reported chest compressions were started but resuscitation efforts ceased once the ICU attending physician arrived and notified the staff on site of the patient's DNAR status. The certified registered nurse anesthetists responding to the code blue reported that, upon arrival, the ICU physician informed them that the code was terminated because of the patient's DNAR status. The ICU physician placed a DNAR order following the patient's death pronouncement and reported being aware that the patient was DNAR status and that this was consistent with end stage Parkinson's.

The OIG determined that since the patient did not have a DNAR order, facility nursing staff treated the patient as a full code status. The ICU nurse reported that a code blue event was called, and chest compressions started because an order for a DNAR did not exist for the patient. The ICU nurse, ICU nurse manager, and two medical-surgical nurses informed the OIG team that if a patient does not have a DNAR order, the patient is considered full code status warranting CPR efforts. The ICU physician reported speaking with the transferring medical team about the patient's DNAR status, but acknowledged the patient did not have the DNAR order. Further the physician acknowledged the medical team did not place a DNAR order upon admission to the ICU, nor at any time before the patient's death.

3. Related Concern: DNAR Documentation and Communication

The OIG determined that although residents and attending physicians reported the patient had a DNAR status, they failed to document a DNAR order and a DNAR progress note and failed to effectively communicate the DNAR status to all appropriate healthcare team members.

DNAR Order and DNAR Progress Note Documentation

The OIG found that residents and attending physicians failed to place a DNAR order or document a DNAR progress note on admission and failed to rewrite DNAR orders upon the patient's transfer from one unit to another.

VHA and facility policy required the attending physician to personally discuss a patient's decision to have medical personnel withhold CPR in the event of a cardiac arrest with the patient prior to entering a DNAR order.⁴⁸ Per VHA and facility policy in effect at the time of the patient's death, a DNAR order was to be written by the attending physician and accompanied by a DNAR progress note that included, at a minimum: the patient's diagnosis and prognosis, the consensual decisions of the treatment team, an assessment of the patient's competency, and the patient's wishes.⁴⁹

Facility policy required an attending physician to write the DNAR order in full as "Do Not Attempt Resuscitation" and include the date, time, and physician's signature, to eliminate any misunderstanding of the patient's decision. When the attending physician was unable to enter the DNAR order, a designee, usually the physician's assigned resident could do so; however, the attending physician was required to authenticate (cosign) the resident's order in the EHR within 24-hours. While residents are involved in managing care, the supervising practitioner (attending physician) is ultimately responsible for the care provided to each patient and must document their involvement in patient care and resident supervision in the EHR.⁵⁰

Further, if a patient was transferred from one unit to another within the hospital, facility policy in effect at the time of the patient's death required the attending physician to rewrite the DNAR order at each transfer.⁵¹

The OIG found that upon the patient's hospital admission, Resident 1 documented the patient's code status as DNAR/DNI [Do Not Intubate] in the History and Physical assessment note in the EHR, but failed to write either a DNAR order or a DNAR progress note as required.⁵² When interviewed, Resident 1 reported being "97.8 percent" confident of having asked the patient about code status at admission, because "if I documented it, I would have asked." Resident 1 acknowledged there should have been a DNAR order and a DNAR progress note in the patient's EHR but may have forgotten to enter the note. Regarding the DNAR order, Resident 1 explained that a resident's DNAR order "does not count" (referring to the requirement that the attending physician had to authenticate the order by either rewriting or cosigning the DNAR order).

The inpatient attending physician entered an admission note documenting agreement with Resident 1's History and Physical assessment but failed to note or correct the absence of a

⁴⁸ VHA Handbook 1004.3; Facility Policy 512-00/PS-012, Do Not Attempt Resuscitation (DNAR) and State Authorized Portable Orders/Maryland Medical Orders for Life-Sustaining Treatment (SAPO/MOLST).

⁴⁹ VHA Handbook 1004.3; Facility Policy 512-00/PS-012.

⁵⁰ Facility Policy 512-14/EA&AA-005, *Monitoring of Resident Supervision*, August 2015. This policy was scheduled for recertification on/before the last working day of August 2018 and has not been recertified; VHA Handbook 1400.01.

⁵¹ Facility Policy 512-00/PS-012.

⁵² Facility Policy 512-00/PS-012; DNI is an abbreviation for Do Not Intubate. Endotracheal intubation is a medical procedure in which a tube is placed into the trachea to support airway management in an emergency. <https://medlineplus.gov/ency/article/003449.htm>. (The website was accessed on May 31, 2019.)

corresponding DNAR order and DNAR progress note. The inpatient attending physician was no longer at the facility and could not be interviewed.

The OIG team reviewed the patient's EHR and found that while physicians documented the patient's DNAR status in physician transfer notes, there were no DNAR orders placed when the patient transferred between medicine units and the ICU except for the DNAR order completed post mortem.

The ICU attending physician stated there should have been a DNAR order in the EHR but said that it takes time to get settled when a patient is first transferred. The physician added that part of residency training is that "things are not always perfect," and that residents need to be careful about writing DNAR orders.

The Chief of Staff reviewed the patient's EHR and when interviewed acknowledged there were multiple missed opportunities for the resident and attending physician to write the DNAR order and DNAR progress note. The Chief of Staff did not know why the orders had been overlooked stating, "I was an attending on the ward for 25 years here, and that was the practice and has been the practice for a very long time."

Facility leaders issued their life-sustaining treatment policy in April 2018 and implemented life-sustaining treatment progress note templates and physician orders in May 2018.⁵³ In alignment with the new VHA policy, residents now have full authority to write DNAR orders, DNAR orders are placed prominently in the patient record, and the orders do not expire or require an update when the patient is transferred between medical units or upon discharge.⁵⁴ Although these changes may streamline the DNAR order process, the resident or physician must still place a DNAR order in the EHR for the order to be acted upon.

Full Code Orders

The OIG determined that residents and attending physicians inadvertently wrote full code orders, directing facility staff to initiate CPR on a patient who had a DNAR status.

While onsite the OIG team discovered that the facility telemetry order set contained a full code order to begin CPR. The patient's EHR revealed that residents entered three full code orders, through the telemetry order set, for the patient during the hospitalization. Nursing staff verified (acknowledged receipt of) these orders which provided clear directions to initiate life-sustaining treatment including to "begin CPR." "defibrillate at 360 watt/sec [wattage per second]," and

⁵³ Facility Policy 512-102/GEC-032, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals, and Preferences*, April 2018. This policy was not yet in effect at the time of the patient's death in 2017.

⁵⁴ Crosswalk - VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, March 30, 2017.
<https://www.ethics.va.gov/LST/PolicyChanges.pdf>. (The website was accessed on December 11, 2018.)

“maintain open airway and ventilate with oxygen 100%.” These orders directly conflicted with the DNAR status documented in residents’ and the attending physician’s progress notes.

Facility residents, physicians, and leaders told the OIG they were not aware of the discrepancy between the telemetry full code order set and the DNAR order process. The OIG team determined this to be a patient safety issue and brought it to the attention of the Chief of Staff for consideration. The OIG team verified that the full code orders were removed from the telemetry order set on February 8, 2019.

Communication of DNAR Status

The OIG determined that attending physicians failed to effectively communicate the patient’s DNAR status to the nursing staff.

VHA policy states that, “[I]t is the responsibility of the attending physician to ensure that the [DNAR] order and its meaning are discussed with appropriate members of the medical center staff, particularly the nursing staff, so that all involved professionals understand the order and its implications.”⁵⁵

The OIG found that the majority of the nurses understood the patient to have a full code status, while physicians understood the patient’s status to be DNAR, as evidenced by the inconsistent documentation in the patient’s EHR. The OIG team conducted a review of 13 EHR admission and transfer notes entered during the patient’s hospital stay, seven of which were entered by physicians and six by nursing staff. All seven physician notes indicated that the patient was a DNAR code status. Of the six transfer notes entered by nurses, three indicated that the patient was full code status, two failed to document the patient’s code status, and one identified the patient as DNAR.⁵⁶ See appendix A for additional information on code status documentation.

When the ICU attending physician was asked how nurses would be aware of a patient’s DNAR status in the absence of an order, the physician acknowledged there should have been an order but said, “they go by orders, but I go by notes.” The physician stated that the EHR physician transfer notes clearly indicated the patient was DNAR and added that the code status had been discussed with the team. The physician reported that when the code was called off “staff were surprised” that the patient was a DNAR, which prompted this physician to enter a DNAR order post mortem.

⁵⁵ VHA Handbook 1004.3.

⁵⁶ Facility SOP, *Handoff (ISBARQ)*, November 2016. This SOP policy requires nurses to provide a handoff when the patient care is transferred from one nurse to another, such as shift changes, lunch breaks, and transfers to another level of care. Facility Policy 512-00/PS-012, *Do Not Attempt Resuscitation (DNAR) and State Authorized Portable Orders (SAPO)*. This policy outlined the patient health information that must be included in the handoff communication, to include the patient’s code (DNAR) status.

Through interviews, facility nurses, a nurse manager, the ADPCS, and the Chief of Staff uniformly stated that nurses require a physician order to take action, and that in the absence of a DNAR order in a patient's EHR, they would consider the patient as full code. The ADPCS further stated that because the patient had full code orders, the code status may not have been communicated between nurses during a nursing handoff or transfer; whereas, if the patient had a DNAR order, it would be included.

The OIG found that the absence of physician DNAR orders and progress notes, the presence of contradictory full code orders through the telemetry order set, and the lack of effective physician communication to the nursing staff resulted in the patient's healthcare team not having the correct information needed to appropriately intervene when the patient became unresponsive.

4. Related Concern: Facility Leaders Failed to Follow up on a Patient Safety Concern Related to Parkinson's Medication Contraindications

The OIG found that facility leaders and managers were informed of a pharmacy systems issue and failed to ensure that the related action item was completed.

VHA safety program goals are to prevent harm to patients and build a culture of safety. Accomplishing these goals requires "reviewing adverse events and close calls to identify underlying causes and implementation changes needed to reduce the likelihood of recurrence."⁵⁷ Management reviews of adverse events and close calls may occur through processes including root cause analysis, peer review, and disclosures.⁵⁸ When an organization identifies a system issue, facility managers may initiate a management review process.⁵⁹

The Executive Committee of the Medical Staff (ECMS) consists of members from facility leadership, management, and various clinical center staff. The ECMS is the facility's medical oversight committee and functions include: review credentialing and privileging processes; ensures compliance with VHA standards, performance measures, and relevant external standards; receive and act upon reports and recommendations from facility medical staff committees; and provide a line of communication between the medical staff and facility

⁵⁷ VHA Handbook 1050.01, *National Patient Safety Improvement Handbook*, March 4, 2011. This VHA Handbook was scheduled for recertification on or before the last working day of March 2016, and has not been recertified.

⁵⁸ VHA Handbook 1050.01; VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010. This VHA Directive was rescinded on November 21, 2018, and replaced by VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

⁵⁹ VHA Directive 2010-025.

Director.⁶⁰ VHA and facility policy require the ECMS to review and determine a need for further action of system's issues reported through a quality management committee.⁶¹

The OIG team reviewed the patient's care and identified a patient safety issue related to the administration of haloperidol in patients with Parkinson's and noted that the ECMS documented the issue as an action item in fall 2018.⁶² The ECMS minutes noted, "the use of the medication haloperidol in Veterans with Parkinson disease could be fatal. It was suggested, to place a Hard Stop by Pharmacy as an Allergy or an MUE [medication-use evaluation] or Flag Chart [alert] in relation to the Disease with list of meds [medications] not to be given." The action item identified a collaboration between the medicine, pharmacy, and ambulatory and emergency care services to address the issue of haloperidol use in patients with Parkinson's, with no target date specified.

During the next month ECMS meeting, the action item was assigned to Pharmacy Services "to review, discuss, and present at the Pharmacy & Therapeutics Committee (P&T)."⁶³ VHA requires Pharmacy Services to identify medication-related problems and implement measures to improve medication safety, including adverse drug event reporting and multidisciplinary analysis.⁶⁴ The facility Pharmacy and Therapeutics Committee is responsible for defining "policy for safe and therapeutically effective drug use and to evaluate the clinical outcomes of the drug therapy provided."⁶⁵ The committee monitors drug usage and evaluates adverse events specific to certain high-risk patient populations and reports its findings to the ECMS on a quarterly basis.

The item was later closed at the late fall 2018 ECMS meeting; however, the committee minutes did not reflect a discussion or outcome of the use of haloperidol in Parkinson's patients. The OIG team requested an update regarding the follow-up and closure. The Director of Risk Management performed a review of meeting minutes and reported to the OIG team "there was no evidence in the Pharmacy and Therapeutics Committee Meeting minutes" that there was follow-up or discussion on this issue.⁶⁶

The Chief of Pharmacy did not recall any discussions regarding this haloperidol medication issue until February 2019, when the open action item regarding the implementation of a clinical alert notifying providers of a potential risk of medication-disease interaction was brought forward. On April 16, 2019, the Director of Peer Review, Patient Safety, and Infection Control provided

⁶⁰ Facility Medical Staff Bylaws 2017-2020, October 16, 2017.

⁶¹ VHA Directive 2010-025; Facility Policy 512-00/PS 004, *Peer Review Process*, September 2017.

⁶² VHA Directive 2010-025; Facility Policy 512-00/PS-004.

⁶³ The OIG team obtained this information from a review of the facility's Executive Committee of the Medical Staff meeting minutes in August 2018 and September 2018.

⁶⁴ VHA Directive 1108.06.

⁶⁵ Facility Policy 512-119-036, *Pharmacy and Therapeutics Committee*, October 2017.

⁶⁶ The OIG team obtained this information from the Director of Risk Management, Patient Safety and Infection Control on February 15, 2019.

documentation indicating that a medication alert was implemented April 15, 2019, for both inpatient and outpatient pharmacy, and states. "Haloperidol SHOULD NOT BE USED [sic] in patients with Parkinson's Disease!"

Delays in the completion of the ECMS action item may have also delayed effective change related to medication contraindications.

5. Related Concern: Code Blue Documentation

The OIG found provider and nursing code blue documentation was deficient. The OIG determined that the facility's existing measures to identify challenges with resuscitation processes and develop strategies and actions for improvement were insufficient and that the Chief of Staff and ADPCS failed to hold clinical staff responsible for code blue documentation.

Code Blue Documentation

Following the code blue alert on the patient, the OIG found that neither the designated provider nor the nurse completed the post code event progress notes in the EHR, and there was no evidence that a code critique was submitted to the CPR Committee following the code event.⁶⁷

Facility policy required the code leader, a physician, document the code blue event in the EHR using a Code Blue/Rapid Response (provider) progress note. The code recorder, a nurse, was required to complete a Code Blue/Rapid Response (nursing) note in the EHR, in addition to completing and sending a Code Blue/Rapid Response Critique note to the CPR Committee.⁶⁸ The responding anesthesia provider was also required to document the code event in the EHR.⁶⁹ The ADPCS was responsible for ensuring that nursing staff submit appropriate documentation for code blues to the CPR Committee within 48 hours of each code event. The Chief of Staff has overall responsibility to ensure CPR efforts are addressed as required by facility policy.⁷⁰ Neither the ADPCS nor the Chief of Staff ensured code blue documentation requirements were met per facility policy.

Additional EHR Reviews

The OIG reviewed the EHRs of six additional patients to determine if the DNAR and code blue documentation deficiencies were isolated to the patient under review; the OIG team found

⁶⁷ Facility Policy 512-11 COS-036, *Medical Emergency Response Teams*, January 2015. The critique note is an appraisal of the code event submitted to the facility's Resuscitation Committee.

⁶⁸ Facility Policy 512-11 COS-036.

⁶⁹ Facility SOP NO. 115/ACCC-004, *Code Blue/Rapid Response*, February 2016. This policy was scheduled for recertification on or before the last working day in February 2019.

⁷⁰ Facility Policy 512-11 COS-036.

similar code blue documentation deficiencies and identified one patient who had a DNAR order but was subject to a code blue.

The six patients were selected from a summary of resuscitation events for fiscal year 2017 and a summary of code blue calls for November through December 2017 and June 2018. All patients reviewed had a code blue call initiated on their behalf. The OIG found the following documentation deficiencies for the patients reviewed:

- Three of the six patient records were missing the Code Blue/Rapid Response (provider) notes.
- One patient record did not have a related anesthesiology note documenting the code blue event.
- One patient had a DNAR order but was subject to resuscitation events for several minutes until the team leader canceled the code based on the DNAR order.

Oversight of Resuscitation Efforts—Code Blue Events

The OIG determined that facility leaders failed to monitor and rectify gaps in clinical staff's code blue documentation.

In accordance with The Joint Commission standards, VHA policy required each facility to establish a CPR Committee.⁷¹ Facility policy designated the CPR Committee to be responsible for reviewing each code blue event, including related clinical notes in the EHR and code critique notes, to identify opportunities for improvement in the processes and/or outcomes of resuscitation events. The individual and aggregate data was to be used to “identify problems, analyze trends, benchmark for opportunities for improvement, and when problems are determined, recommend specific actions and ensure implementation of those actions.”⁷²

A Quality, Safety & Improvement representative was to serve as a committee member to ensure each CPR event met the standards of care and that local policies were followed. The representative was responsible for “[p]roviding information to the VAMHCS [VA Maryland Health Care System] Chief of Staff through the Quality Improvement and Safety Director and VISN Quality Management Officer.”⁷³

⁷¹ VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitation Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008, rescinded by VHA Directive 1177, August 28, 2018. This directive was in effect during the scope of this inspection; TJC PI 01.01.01 10. The hospital must measure, analyze, and track quality indicators and other aspects of performance to include the results of resuscitation events. <https://e-dition.jcrinc.com/MainContent.aspx>. (The website was accessed on April 15, 2019.)

⁷² Facility Policy 512-11-COS-127, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Cardiopulmonary Resuscitation Committee*.

⁷³ Facility Policy 512-11-COS-127.

The OIG determined that although VHA and facility policy required a representative from “Quality, Safety & Improvement” to serve on the CPR Committee, there was no evidence of attendance in committee meeting minutes.

The CPR Committee co-chair informed the OIG team that the committee was originally a subcommittee of the Critical Care Committee; however, identified issues and concerns were not reported to facility leaders.⁷⁴ The OIG team reviewed Critical Care Committee and ECMS meeting minutes and found no references to the patient, code blue documentation, or CPR. Reportedly, the CPR Committee began reporting to the Executive Performance Improvement Council, chaired by the facility Director, in April 2018.

In addition to the CPR Committee, the ADPCS assigned two performance improvement registered nurses the responsibility for tracking and analyzing hospital performance improvement measures to include inpatient resuscitation efforts, required code blue documentation, and the early identification of patient risk factors.

The performance improvement nurses reported that once they identified missing code blue documentation, they notified physicians, nurses, ICU managers, and clinical service chiefs through email, requesting completion. They do not monitor for completion or compliance, as the expectation is that the documentation deficiencies are corrected at the service level.

The OIG team reviewed emails provided by the performance improvement nurses and confirmed their efforts to notify code blue/rapid response team members and clinical managers and leaders of missing documentation. One particular email that the nurses sent in late fall 2017 to physicians, nurses, the anesthesiology service, clinical managers, the CPR Committee co-chair, and the ADPCS notifying them that there were 32 missing Code Blue/Rapid Response team notes for the prior month, including two progress notes for the subject patient.

The OIG team noted that despite the performance improvement nurses’ email notification regarding missing code blue documentation sent in late fall 2017, when the OIG team reviewed the patient’s EHR in January 2019, the deficiencies remained.

Conclusion

The OIG substantiated that the patient died due to aspiration pneumonia, and subsequent cardiopulmonary arrest, and that facility staff attempted resuscitation. The specific cause of the event leading to cardiopulmonary arrest could not be determined. Moreover, the death certificate identified the cause of death as aspiration pneumonia due to dysphagia and Parkinson’s.

⁷⁴ For the context of this report, “facility leaders” refers to VA Maryland Health Care System leaders.

The OIG was unable to determine whether the cause of death by aspiration pneumonia constituted a “wrongful” death, or that any action by facility staff contributed to the aspiration pneumonia.

The OIG found that facility staff inaccurately documented the history of medication administration and based further clinical decisions on such documentation. The OIG team could not determine if the documentation inaccuracies contributed to any adverse clinical outcomes.

The OIG team substantiated that facility staff attempted resuscitation on a patient with a DNAR status; however, there was no DNAR order in the EHR when resuscitation was attempted. The ICU attending physician reported speaking with the transferring medical team about the patient’s DNAR status but acknowledged the patient did not have the DNAR order. The physician acknowledged the medical team did not place the DNAR order upon admission to the ICU, nor through the time of the patient’s death.

The OIG determined that residents and attending physicians did not comply with documentation requirements for DNAR orders and DNAR progress notes and failed to effectively communicate the DNAR status to all appropriate healthcare team members.

The OIG found that residents and attending physicians failed to write a DNAR order or progress note at admission and failed to rewrite DNAR orders upon the patient’s transfer from one unit to another. The OIG determined that residents and attending physicians wrote full code orders, through a telemetry order set, directing staff to initiate CPR; these orders directly conflicted with the DNAR status documented in resident and attending physician’s EHR progress notes. While onsite, the OIG team brought this concern to the Chief of Staff for action; the OIG team verified that the full code orders were removed from the telemetry order set on February 8, 2019.

The OIG determined that attending physicians failed to effectively communicate the patient’s DNAR status to the nursing staff. As a result, the OIG team found EHR admission and transfer documentation of the patient’s code status to be inconsistent between physician and nursing staff. The OIG found that the absence of physician DNAR orders and progress notes, the presence of contradictory full code orders through the telemetry order set, and the lack of effective physician communication to the nursing staff resulted in the patient’s healthcare team not having the correct information needed to appropriately intervene when the patient became unresponsive.

The OIG found a pharmacy systems issue identified in ECMS meeting minutes that facility leaders and managers failed to take action on and monitor through completion. Specifically, the early fall 2018 ECMS meeting minutes identified a patient safety issue related to the administration of haloperidol in patients with Parkinson’s and tasked the issue to the Pharmacy and Therapeutics Committee for action. The issue was closed without action in late fall 2018, ECMS meeting minutes and was not fully addressed until the OIG requested a status update in February 2019.

The OIG found resuscitation code blue documentation deficiencies including the required Code Blue/Rapid Response provider and nursing note and the Code Blue/Rapid Response Critique note. The OIG determined that the facility's existing measures to identify challenges with resuscitation processes and develop strategies and actions for improvement were insufficient. The OIG found that the Chief of Staff and ADPCS failed to hold clinical staff responsible for code blue documentation.

Recommendations 1–4

1. The VA Maryland Health Care System Director reviews the subject patient's final episode of care and treatment course and determines if administrative actions are appropriate.
2. The VA Maryland Health Care System Director establishes a process to monitor the identification, documentation, and communication of patients' Do Not Attempt Resuscitation status.
3. The VA Maryland Health Care System Director reviews the process for tracking, documenting, and completing action items in the Executive Committee of the Medical Staff.
4. The VA Maryland Health Care System Director strengthens the process for tracking code blue/rapid response events to include timely completion of the required documentation and accountability for delinquent documentation.

Appendix A: Documentation of Code Status and Subject Patient Transfers

Date	Patient Event/Location	Document Type	Documented Code Status
Hospital Day 1	Transfer from Emergency Department to Medicine Unit	Medical Admission History and Physical Note	Code Status: DNR/DNI; Advance Directive (2008)
	Medicine unit	Telemetry Orders/ACLS ⁷⁵ Guidelines	Full code order Begin CPR
Hospital Day 2	Transfer from Medicine Unit to ICU	Nursing Admission Assessment Note	No code status documented
	ICU	Telemetry Orders/ACLS Guidelines	Full code order Begin CPR
Hospital Day 3	Transfer from ICU to Medicine Unit	Nursing Transfer Discharge Note	Full code
	Transfer from ICU to Medicine Unit	Nursing Admission Evaluation Note	No code status documented
Hospital Day 4	Transfer from Medicine Unit to ICU	Transfer Summarization Note	DNR/DNI; Advance Directive on file
	Transfer from Medicine Unit to ICU	Nursing Discharge Transfer Note	Full code
	Transfer from Medicine Unit to ICU	Interservice Incoming Transfer Note	Code Status: DNR/DNI; Advance Directive (2008) ⁷⁶
Hospital Day 6	Transfer from ICU to Medicine Unit	Interservice Outgoing Transfer Note	DNR/DNI

⁷⁵ Facility Policy 512-11-COS-038, *Staff Training in Cardiopulmonary Resuscitation (CPR) and Advanced Cardiac Life Support (ACLS)*, January 2015. Updated and replaced by Facility Policy 512-11-COS-038, *Cardiopulmonary Resuscitation*, November 2018, Advanced Cardiac Life Support (ACLS) is defined as, “a set of life-saving protocols and skills that extend basic life support (BLS) to further support the circulation and provide an open airway and adequate ventilation (breathing).”

⁷⁶ The transfer note referred to the patient’s Advance Directive completed in 2008.

Alleged Wrongful Death and Deficiencies in Documentation of a Patient's
DNAR Status at the Baltimore VA Medical Center, Maryland

Date	Patient Event/Location	Document Type	Documented Code Status
Hospital Day 7	Transfer from ICU to Medicine Unit	Interservice Incoming Transfer Note	DNR/DNI
Hospital Day 8	Transfer from ICU to Medicine Unit	Nursing Discharge-Transfer Summarization Discharge Note	DNR/DNI
Hospital Day 10	Transfer from Medicine Unit to ICU	Nursing Transfer Summarization Discharge Note	Full code
Hospital Day 11	Transfer from Medicine Unit to ICU	Interservice Incoming Transfer Note	DNR/DNI; Advance Directive on file (2008)
	ICU	Telemetry Orders/ACLS Guidelines	Full code order Begin CPR
	Transfer from Medicine Unit to ICU	Interservice Outgoing Transfer Note	DNR/DNI
	ICU	DNAR Order (documented after patient died)	Patient is DNAR and DNI per his wishes. Do not intubate or resuscitate.

Source: OIG staff analysis of EHR via Joint Legacy Viewer

Appendix B: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 28, 2019

From: Director, VA Capitol Health Care Network (10N5)

Subj: Healthcare Inspection—Alleged Wrongful Death and Deficiencies in Documentation a Patient's
Do Not Attempt Resuscitation Status, Baltimore VA Medical Center, Maryland

To: Director, Office of Healthcare Inspections (54HL07)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. I have reviewed and concur with the findings and recommendations in the Office of Inspector General's (OIG's) draft report entitled - Alleged Wrongful Death and Deficiencies in Documentation of a Patient's DNAR Status.
2. Further, I have reviewed and concur with the VA Maryland HCS, Medical Center Director's response.
3. Thank you for this opportunity to focus on continuous performance improvement. If you have any questions, please feel free to contact the Acting Quality Management Officer, Mary Tatum, at Mary.Tatum@va.gov.

(Original signed by:)

Robert M. Walton, FACHE
Director, VA Capitol Health Care Network (10N5)

Appendix C: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: October 28, 2019

From: Director, VA Maryland Health Care System (512/00)

Subj: Healthcare Inspection—Alleged Wrongful Death and Deficiencies in Documentation of a Patient's Do Not Attempt Resuscitation Status, Baltimore VA Medical Center, Maryland

To: Director, VA Capitol Health Care Network, (10N5)

1. I would like to express my appreciation to the Office of Inspector General Survey Team for their professional and comprehensive review of the "Alleged Wrongful Death and Deficiencies in Documentation of a Patient's Do Not Attempt Resuscitation Status, Baltimore VA Medical Center, Maryland" report.
2. I have reviewed the draft for the VA Maryland Health Care System, Baltimore, Maryland, and concur with the findings and recommendations.
3. Please express my gratitude to the survey team for their professionalism and assistance to us in our continuing efforts to provide the best care possible to our Veteran patients.

(Original signed by:)

Jonathan Eckman
Acting Medical Center Director *for*.

Adam M. Robinson, Jr., M.D.
Director, VA Maryland Health Care System

Facility Director's Response

Recommendation 1

The VA Maryland Health Care System Director reviews the subject patient's final episode of care and treatment course and determines if administrative actions are appropriate.

Concur.

Target date for completion: December 1, 2019

Director Comments

An internal medical peer review of the patient's episode of care was completed in March 2018. An external review of the care was completed with relevant administrative actions completed in May 2018. Additionally, a Root Case Analysis (RCA) will be completed to ensure a systematic review of potential process gaps and patient safety vulnerabilities.

Recommendation 2

The VA Maryland Health Care System Director establishes a process to monitor the identification, documentation, communication, of patients' Do Not Attempt Resuscitation status.

Concur.

Target date for completion: November 1, 2019

Director Comments

The VA Maryland Health Care System's process of monitoring patients' Do Not Attempt Resuscitation status will be reviewed to ensure that identification, documentation, and communication are consistent.

To ensure consistent documentation, providers will complete Life-Sustaining Treatment (LSTDI) documentation on all patients admitted as a medical or surgical patient. The LSTDI note will consist of order reflecting the code status. To ensure compliance, the Office of Quality, Safety, Improvement will monitor and report compliance of timely, completion of the LSTDI note.

OIG Comment

The OIG considers this recommendation open to allow time for the submission of documentation to support closure.

Recommendation 3

The VA Maryland Health Care System Director reviews the process for tracking, documenting, and completing action items in the Executive Committee of the Medical Staff.

Concur.

Target date for completion: November 30, 2019

Director Comments

The Facility Chief of Staff will implement a tracking mechanism within the Executive Committee of the Medical Staff meeting minutes that ensures that action and suspense items are appropriately completed, tracked, and documented prior to closing of assigned actions. Minutes will reflect updating and request for closure prior to documentation of closure on an action items tracking sheet that will be included as an attachment to the minutes in accordance with VA Maryland Health Care System Policy Memorandum 512-00-111.

Recommendation 4

The VA Maryland Health Care System Director strengthens the process for tracking code blue/rapid response events to include timely completion of the required documentation and accountability for delinquent documentation.

Concur.

Target date for completion: November 30, 2019

Director Comments

The VA Maryland Health Care System will review and revise the facility process for code blue/rapid response events to ensure timely completion of required documentation. The process will include a communication pathway for consistent, timely notification of delinquent documentation to ensure accountability of completion.

Residents will notify attending physicians of all rapid response and code blue events. A facility Rapid Response/Code Blue policy memorandum will be developed to reflect a process that requires residents to notify attending physicians of all rapid response and code blue events. Within 24 hours, attendings will ensure that all resident notes have the appropriate documentation and reflect concurrence by a signature, or addendum of the resident's note. To ensure compliance the Office of Quality, Safety, and Improvement will review and report all code/rapid response events for completion of required documentation. Delinquent documentation will be reported to the Clinical Center Directors and Chief of Staff's Office for proper administrative action. Additionally, facility level monitoring will be reported monthly through the CPR and Executive Quality Committees.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
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