Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00533-440

Healthcare Inspection

Delay in Emergency Airway Management and Concerns about Support for Nurses VA Northern California Health Care System Mather, California

July 28, 2015

Washington, DC 20420

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Executive Summary

At the request of Congressman Ami Bera, M.D., the Office of Inspector General Office of Healthcare Inspections assessed the circumstances of a patient's death at the VA Northern California Health Care System (facility), Mather, CA, and actions taken by staff subsequently. In addition, we reviewed the validity of allegations from two anonymous complainants who alleged:

- Facility staff were uncertain of the patient's preferences regarding cardiopulmonary resuscitation, resulting in a treatment delay.
- An incorrect *Do Not Resuscitate/Do Not Intubate* band was placed on the patient's wrist.
- An estimated cardiopulmonary resuscitation delay of 4–5 minutes contributed to the patient's death.
- Staff were afraid to speak up [voice opinions] because of a culture of bullying and retaliation on the medical-surgical inpatient unit.
- Nurse leaders were not in the building during the incident to "defend or help nurses process" the event.
- An anesthesiologist berated staff participating in the code in a public hallway.

We found that facility staff did not follow through on the patient's request upon admission to discuss advance directives. We found no evidence of advance care planning discussion during the patient's hospital stay.

We substantiated that the patient's wristband had the incorrect code status of *Do Not Resuscitate/Do Not Intubate* printed on it and that staff did not verify the wristband code status during the patient's 9-day hospital stay. We also found that the wristband had clinical warnings not pertinent to the patient's current condition. We determined that a contributing factor as to why staff did not identify the incorrect code status might have been that nurses were using a duplicate copy of the wristband as a "workaround" when administering medications.

We substantiated that the incorrect code status on the patient's wristband led to a delay in life-saving intervention. We concluded that code status confusion delayed chest compressions, defibrillation pad placement, and medications. The anesthesiologist was turned away and called back later, causing a delay in intubation. Of note, the patient was actively being managed by the code team physician during this time.

Prior to our inspection, the facility had already started to implement corrective actions to ensure that staff verify and document patients' code status. In addition, the facility performed an institutional disclosure of adverse events to the patient's family and conducted a comprehensive review of the care provided for this patient in accordance with Veterans Health Administration policy.

We did not substantiate the allegations that medical-surgical unit staff were afraid to speak up because of the culture of bullying and retaliation on the unit. However, we concluded that an evaluation of the unit is warranted based on the unit's All Employee Survey scores related to supervisory behaviors. Although we confirmed that nurse managers were at a meeting away from the hospital when the patient died, we found that a nursing supervisor and an acting unit manager were available to support staff following the incident. Nevertheless, we concluded that facility leaders need to implement a plan for proactive employee support in response to traumatic events.

We did not substantiate the allegation that a physician berated staff participating in the code.

We recommended that the Facility Director require staff to provide patients information on and assistance with completing advance directives; ensure corrective action plans concerning clinical warnings, including code status, on patient's wristband are fully implemented; conduct an inspection and ongoing monitoring of all inpatient units to ensure nurses do not make copies of wristbands; conduct an evaluation of the medical-surgical unit to determine if there are issues undermining psychological safety at the work place; and develop and implement a plan for employee support following traumatic events.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided acceptable action plans. (See Appendixes A and B, pages 15–20 for the Directors' comments.) We consider recommendations 2 and 3 closed and will follow up on the planned actions in recommendations 1, 4, and 5 until they are completed.

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

Purpose

At the request of Congressman Ami Bera, M.D., the Office of Inspector General (OIG) Office of Healthcare Inspections conducted an assessment of the circumstances of a patient's death at the VA Northern California Health Care System (facility), Mather, CA and actions taken by facility staff subsequent to the death. In addition, we evaluated allegations related to support for nurses.

Background

The facility is a 180-bed (60 acute and 120 community living center) secondary care facility that provides comprehensive health care services in medicine, surgery, and long-term care. It serves veterans through its main medical facility in Mather, CA, and at eight affiliated community based outpatient clinics. The facility provides surgical (general, vascular, and urology) and anesthesiology services. It is part of the Veterans Integrated Service Network (VISN) 21.

Allegations

Congressman Ami Bera, M.D., sent a letter to the VA Secretary requesting that the OIG review the circumstances surrounding an incident that resulted in a patient's death and the facility's actions in response to that death. He requested that the review include any contributing protocols and systems issues along with detailed recommendations for improvement to avoid similar events in the future. Congressman Bera's letter included an e-mail from an anonymous complainant alleging quality of care and administrative concerns. Specifically, the complainant alleged:

- Facility staff were uncertain of the patient's preferences regarding cardiopulmonary resuscitation (CPR), resulting in a delay in CPR.
- An incorrect *Do Not Resuscitate (DNR)/Do Not Intubate (DNI)* band was placed on the patient's wrist.
- An estimated CPR delay of 4–5 minutes contributed to the patient's death.
- Staff were afraid to speak up [voice opinions] because of a culture of bullying and retaliation on the medical-surgical inpatient unit (MSU).
- An anesthesiologist berated staff participating in the code in a public hallway.

The OIG Hotline Division received similar complaints from another anonymous complainant alleging that when the patient became unresponsive, staff debated whether the patient was designated DNR, which delayed CPR for 5 minutes. In addition, the complainant alleged that there were no nurse leaders in the building during the incident to "defend or help nurses process" the event.

Cardiopulmonary Resuscitation

CPR is a procedure to support and maintain breathing and circulation for a person who has stopped breathing (respiratory arrest) and/or whose heart has stopped (cardiac arrest). The American Heart Association previously recommended the following action sequence, also known as the ABC's (airway-breathing-chest compression), for resuscitation:

- Establish a patent airway for air flow;
- Use rescue breaths or a bag-valve mask,[1] if available, for breathing and oxygenation; and
- Start chest compressions to restore and maintain circulation to vital organs.

The American Heart Association's most recent guideline recommends immediate chest compressions for adults suffering from sudden cardiopulmonary arrest using chest compression-airway-breathing (CAB) as the sequence of steps to take.[2] The guideline further suggests that when multiple providers are available, these three tasks could be performed concurrently.

Airway Management

Airway management encompasses the procedures required for establishing and maintaining an open pathway to the lungs in order to ensure adequate oxygenation. In the operating room (OR), airway management occurs prior to and during the use of anesthesia. Anesthesia staff are highly trained to provide this service, especially intubation whereby an endotracheal (ET) tube is inserted from the mouth or nose into the trachea to prevent obstruction and provide air flow.

Facility anesthesia staff provide emergency airway management coverage outside of the OR setting during normal business hours but are on-call and expected to be available onsite within 30 minutes after hours. When anesthesia staff are not immediately available, other certified clinicians designated by the facility (pulmonary and emergency department physicians, hospitalists, and respiratory therapists) provide emergency airway management.

Advance Care Planning, Code Status Designation, and Code Blue

The Veterans Health Administration (VHA) defines procedures for health care staff to support advance care planning for patients.

> *Advance care planning is a process for identifying and communicating an individual's values and preferences regarding future health care for use at a time when that person is no longer capable of making health care*

[1] A hand-held device commonly used to provide lifesaving oxygen to the patient's lungs.
[2] JM Field, et al. 2010 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care Science. *Circulation,* 2010; 122:S640–656.

> *decisions. Advance care planning may, but does not necessarily, result in a written advance directive document.*[3]

The Joint Commission requires hospitals to have written policies on advance directives (AD),[4] forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services (interventions to revive a person who has lost consciousness).[5]

A patient's "code status" describes the procedures that can be performed on a patient if cardiopulmonary arrest occurs based on her/his wishes that were determined during advance care planning. Clinicians provide the appropriate interventions in the event of a medical emergency depending on the patient's code status. The code statuses are:

- DNR – Patients do not receive CPR, defibrillation, and/or medications but may be intubated.
- DNI – Patients do not receive intubation, but chest compressions, defibrillation, and/or medications may be used.
- DNR/DNI – Patients do not receive lifesaving interventions.

A patient is considered "full code" if he/she has not designated a preference. For full code patients, clinicians provide emergency measures such as CPR, electrical defibrillation, and emergency medications in an attempt to resuscitate the patient. Clinicians will intubate patients and connect the intubation tube to a ventilator to assist in breathing.

The facility's DNR policy states that a patient's "attending physician during an inpatient stay or the primary care provider is responsible for determining the propriety of a DNR order." Facility policy requires that a DNR order be preceded by discussions with the attending physician, and if indicated, with Mental Health, Social Work, and/or Nursing staff. The patient is advised to discuss the issue with his or her family before electing DNR status. Lastly, facility policy states that a DNR order must be reviewed and rewritten upon any change in the patient's condition that would significantly affect the medical prognosis.

The facility uses the term *Code Blue* for emergencies such as cardiopulmonary arrest. The staff member who identifies the emergency contacts the telephone operator who announces a *Code Blue* over a public address system. This alerts the code team to go immediately to the patient. The team typically consists of a respiratory therapist (RT), lead physician, provider certified in airway management, pharmacist, and several nurses who have been trained to provide resuscitative care. Some of the challenges with responding to *Code Blue* situations include working in a foreign and chaotic environment with unfamiliar team members and lack of prior knowledge about the patient.

[3] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
[4] A written statement by an individual who has decision-making capacity regarding preferences about future health care decisions in the event that the individual becomes unable to make those decisions.
[5] Joint Commission RI.01.05.01 EP1 standard. Last accessed March 5, 2015.

Patient Identification Wristband System (Biopoint)

The facility uses the Biopoint patient identification software system to generate patient wristbands. The system has a list of clinical warnings such as fall risk and code status (DNR, DNI, and DNR/DNI). These warnings communicate important clinical information and staff are expected to review the electronic health record (EHR) to confirm the information. In accordance with physician orders, when a patient is admitted to the facility for the first time, staff check the appropriate box(es) in Biopoint prior to printing a wristband.

For patients with a prior admission at the facility, the Biopoint identification system stores previously marked clinical warnings, including code status. A staff member, usually an inpatient unit medical support assistant (MSA), is required to check the current physician orders and update previously marked boxes upon a patient's readmission to the facility. The system does not interact with the EHR to provide a warning when staff checks an incorrect box.

VA All Employee Survey

The All Employee Survey (AES) is an "annual voluntary census survey of the VA workforce."[6] The AES uses a 5-point scale, with the lowest possible score 1 (not at all satisfied or strongly disagree) and the highest possible score 5 (very satisfied or strongly agree). In fiscal year (FY) 2014, the facility's employee response rate was 53 percent (1,552/2,917 facility staff responded to the survey), and the response rate from Nursing Service was 64 percent (416/655 nursing staff responded to the survey).

Of the 44 facility MSU nursing staff, 23 responded to the survey. One of the factors measured by the FY 2014 AES included employees' perceptions of supervisory behaviors. In this category, employees were asked to assess the following behaviors:

1. Fairness: My supervisor is fair in recognizing accomplishments.
2. Relationship: I have an effective relationship with my supervisor.
3. Advocate: My supervisor stands up for his/her people.
4. Favoritism: My supervisor does not engage in favoritism.
5. Supervisor Communication: My supervisor provides clear instructions to do my job.
6. Psychological Safety: My supervisor encourages people to speak up when they disagree with a decision.
7. Psychological Safety: I feel comfortable talking to my supervisor about work-related problems even if I'm partially responsible.

For FY 2014, the overall facility scores were generally higher than the national average. However, MSU scores were lower than the average facility scores and generally lower

[6] VHA Support Service Center VA All Employee Survey Portal: http://aes.vssc.med.va.gov/Pages/Default.aspx

than the VISN scores. Table 1 shows the average scores for each element under supervisory behaviors.

Table 1: AES FY 2014 Supervisory Behaviors

Supervisory Behaviors	Fairness	Relationship	Advocate	Favoritism	Supervisor Communication	Psychological Safety (#6)	Psychological Safety (#7)
VHA	3.66	3.89	3.68	3.57	3.72	3.71	3.58
VISN 21	3.73	3.93	3.76	3.62	3.74	3.77	3.64
Facility	3.77	3.98	3.83	3.73	3.73	3.68	3.93
Nursing Service – Roll-Up Group (ALL Nursing)	3.74	3.98	3.89	3.69	3.78	3.73	3.89
Nursing Service – MSU	3.41	3.95	3.45	3.33	3.43	3.00	3.48

Source: VHA

Scope and Methodology

We conducted our work from October 2014 through March 2015, including a facility site visit on January 27–29, 2015. We interviewed facility leaders, physicians, nurses, and administrative staff. We inspected the MSU and the intensive care unit (ICU) and traced the path taken by the code team anesthesiologist. We conducted an unannounced evening inspection of the MSU and the ICU. We attempted without success to obtain a report of the autopsy which was completed at a non-VA facility.

We reviewed VHA and local policies, Joint Commission standards, facility internal review reports, American Heart Association guidelines, emergency airway management literature, FY 2014 AES results, the patient's EHR, and other relevant documents.

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

Case Summary

The patient, a man in his 60s, who had a history of hypertension, post-traumatic stress disorder, depression, and peripheral vascular disease was hospitalized for elective aortofemoral bypass surgery.[7] Pre-operative notes and orders included no mention of his preferences regarding resuscitation in the event of cardiopulmonary arrest. On admission, a patient services assistant wrote in a template note that the patient said he did not have an AD and "would like to discuss the completion/update of an AD with a health care provider."

The surgeon performed the operation without complications, and the patient was transferred to the ICU on the same day. The ICU nursing admission note stated that the patient's "code status was not determined yet, will remind provider." By the next day, the patient was stable for transfer to the MSU. However, because there were no beds available in the MSU, he remained in the ICU as a boarder until post-operative day 7.

On post-operative day 3, he developed nausea and vomiting and was diagnosed with a mild ileus (a small intestine obstruction due to the lack of peristalsis[8]), a common complication of abdominal surgery and the use of pain medication. He was asked not to eat or drink anything by mouth, and his symptoms resolved by the next day without further interventions.

The patient's course was uneventful until post-operative day 7 when he developed a lymphatic leak in the groin. He returned to the operating room for a myoplasty, a procedure involving the translocation of a leg muscle flap to cover the leak. After this surgery, the patient was transferred back to the ICU and then moved to the MSU when a bed became available. The nursing transfer note stated the patient was full code.

On the following day, post-operative day 8 from the initial surgery, the patient developed nausea and vomiting, and an x-ray of his abdomen again indicated an ileus. Later that evening, the vascular surgery team visited the patient and explained the treatment options. The team recommended placement of a nasogastric tube (NGT).[9] However, the patient wanted to wait and see if the obstruction would resolve without an NGT.

Later that evening, the patient developed more nausea and vomiting and agreed to NGT placement. The night shift nurse made two attempts to place an NGT before the patient complained of pain and declined any more attempts. The nurse notified the on-call resident and informed him of this development at approximately 2:00 a.m. on post-operative day 9. Members of the surgery team checked on the patient in the

[7] Aortofemoral bypass surgery is a procedure that reroutes blood from the abdominal aorta to the two femoral arteries in the groin. This surgery is performed when the buildup of fatty deposits (plaque) in an artery has blocked the normal flow of blood that carries oxygen and nutrients to the lower extremities.
[8] Peristalsis is the involuntary constriction and relaxation of the muscles of the intestine.
[9] An NGT is a tube that is placed from the nose into the stomach and attached to a suction machine to decompress the stomach.

morning. The team determined that he was improving but that his abdomen was still distended, so they again recommended a NGT, but the patient again declined.

The day shift nurse noted that the patient ambulated with a walker and had a bowel movement that morning. The nurse later heard the patient cry for help in the bathroom inside his room. She called a *Code Blue* immediately after the patient became unresponsive, and the code team arrived to assist with the patient's care. Despite the team's intervention, the patient died, presumptively, from aspiration of gastric contents. More detailed information is found later in the report.

Inspection Results

Issue 1: Advance Directives and Code Status

Lack of Follow Through on Request for Advance Directives Discussion

We found that the facility did not fully comply with VHA policy on ADs. VHA requires notification and screening regarding ADs.[10] Patients must be asked whether they have an AD or whether they want more information and/or assistance in completing forms. VHA requires AD screening and documentation at each admission to a facility.

Upon his hospital admission, the patient reported that he did not have an AD and that he would like to discuss the completion/update of an AD with a health care provider. Although the patient was hospitalized for 9 days, we did not find documented evidence that facility staff followed up on the patient's request or that a discussion took place.

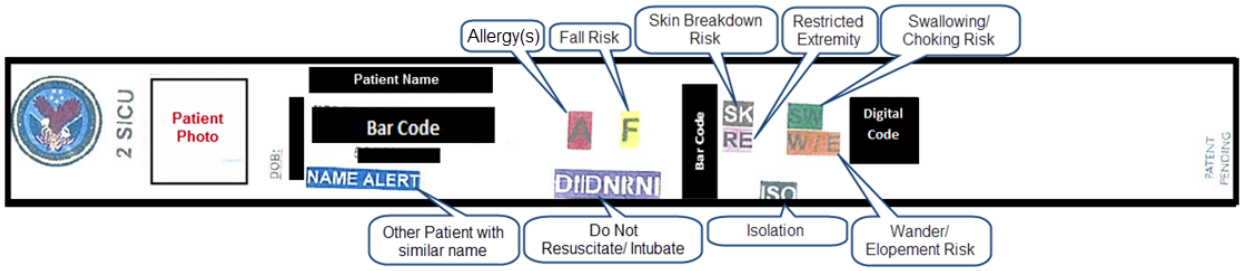
Incorrect Code Status Printed on the Patient's Wristband

We substantiated that the incorrect code status was printed on the patient's wristband and found that multiple factors contributed to the error. We found no documentation that the surgeon discussed with the patient his preferences for resuscitation; however, at this facility, patients who consent to undergo surgical procedures are generally considered to have agreed to a "full code" status.

The patient's identification wristband was printed on the day of admission to the ICU.[11] The Biopoint identification system used to generate the wristband required the MSA to click a box for the DNR code status. The wristband had multiple abbreviations in small font, and nursing staff used a separate legend that was posted on the nursing unit for interpretation. Depending on the location of the indicators on the band encircling the patient's wrist, the DNR/DNI letters could be on one side of the patient's wrist while his/her name and social security number were on the other side. Exhibit 1 on the next page is a scanned copy of the patient's wristband that contained his identity (identifying information has been removed) and the clinical warnings of his condition and risks. The bubbles are added descriptions of the clinical warnings.

[10] VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
[11] Surgical patients have temporary wristbands for the surgical procedure. Once a patient is admitted, a new wristband is printed and placed on the patient.

Exhibit 1: Patient's Wristband



Source: VHA, VA OIG

In addition to the DNR/DNI code status, the patient's wristband contained other clinical warnings or alerts that were not pertinent to the patient. Of the nine boxes representing clinical alerts, only two—allergy and fall risk—accurately represented the patient's status or risks at the time of his admission. We found no documentation supporting the remaining clinical alerts. Facility staff could not determine why all the alert boxes were checked off and concluded that either staff inadvertently checked all boxes without verifying the need for the clinical alerts in the patient's EHR or a "glitch" with the Biopoint system automatically selected the alerts. There is no alert for full code.

None of the staff verified the wristband information on admission or throughout the patient's 9-day hospital stay. Nursing staff did not have a standardized process for verification of wristband clinical alerts during hand offs or changes of shift.

Staff informed us that ICU nurses were using a duplicate copy of the wristband as a "workaround," a possible reason the staff did not identify the wristband error. When administering medications, VHA requires nurses to verify the patient's identity (name and full social security number) before scanning the bar code on the wristband.[12] The wristband and all medication containers prepared by the pharmacy include a bar code unique to the patient. If the patient is unable to communicate, two nurses must verify the wristband identification information. The bar code on each medication is also scanned to ensure the proper medication is given to the correct patient. By having a duplicate copy of the wristband, a nurse could bypass this procedure by scanning the bar code and medications before walking into a patient's room.

Staff reported that sometimes the bar code was cut out of the duplicate copy and taped to the chart without the patient's name or code status. During an unannounced evening inspection of the ICU and MSU, we found duplicate copies of wristbands on nurses' clipboards in the ICU, and staff described their practice of cutting out the bar code section from wristbands. This practice affords a possible explanation for why so many shifts went by without anyone noticing the patient's incorrect information on the wristband. The patient spent 7 days of his hospital stay in the ICU and 2 days in the MSU. We did not find evidence of this practice on the MSU.

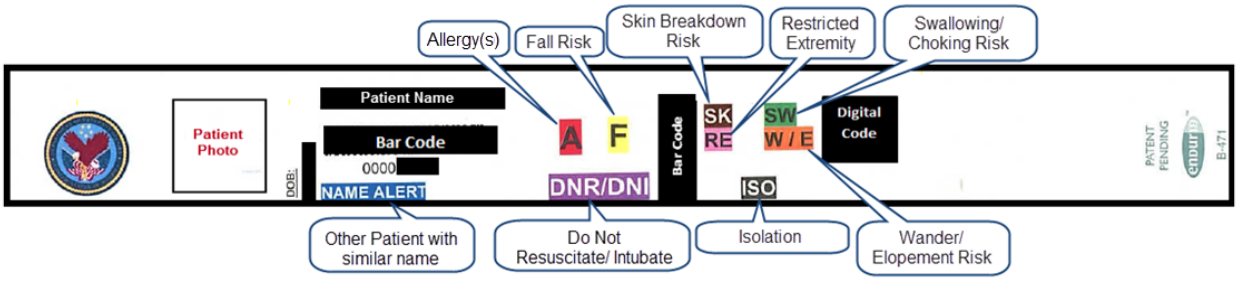
[12] Bar Code Medication Administration (BCMA) GUI User Manual, Version 3.0, Revised December 2013.

The facility acknowledged the incorrect code status error on the patient's wristband and performed an institutional disclosure of adverse events to the patient's family on October 20, 2014. The OIG team learned that the facility had already implemented multiple corrective actions.

Exhibit 2 below shows the previous (old) and the newly redesigned (implemented on January 29, 2015) wristbands in use at the facility.

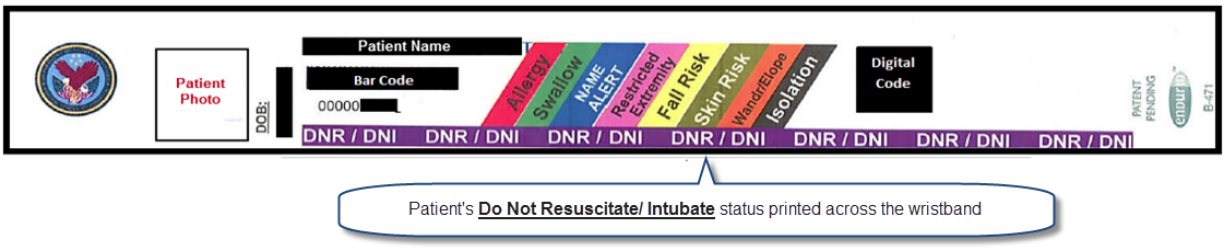
Exhibit 2: Patient Identification Wristbands

Old Design: Previous Wristband



Source: VHA, VA OIG

Redesigned Wristband: as of January 29, 2015



Source: VHA, VA OIG

Incorrect Code Status Led to Delay in Life-Saving Intervention

We substantiated that the wrong code status on the patient's wristband led to a delay in a lifesaving intervention.

By reports, the patient was improving on the morning of his death. The nurse assisted him back to his bed after a bowel movement. The patient called his brother, informing him that he did not need an NGT because he had a bowel movement (typically a sign that the peristalsis resumed, and bowel function has returned). His nurse then returned to her computer, just outside the room.

Shortly later, she heard a cry from the bathroom and found the patient lying on the floor with a pulse and breathing. The patient initially had muscle tone and was able to move back up on the toilet with the nurse's assistance. His head and body were leaning on the wall next to the toilet and supported by the nurse on the other side. After he sat down on the toilet, he had copious vomiting and became limp and unresponsive. The nurse went to his bedside phone, about 6 feet away, and called a *Code Blue* before

going back to assist the patient. The code team arrived with a crash cart[13] outside the bathroom, and the staff moved the bed close to the bathroom door. Staff lifted the patient off the toilet and onto the bed. The patient continued to vomit.

Once on the bed, the staff turned the patient to his left side to allow vomit to flow out without occluding the airway (the recovery position recommended for vomiting unconscious patients). Nurses set up suction equipment as the patient continued to vomit. The RT and a nursing supervisor both suctioned the patient while the code team physician prepared intubation equipment. Starting at 3 minutes after the Code Blue call, the RT attempted to perform bag-valve mask ventilation. However, he stated that this was very difficult, as the patient continued to vomit. The RT and nurse tried to suction around the mask and in between breaths. The copious vomiting likely affected the quality of the ventilation they were able to provide.

The code team physician tried to ascertain the patient's code status. He noted in the EHR:

> *We were informed by staff at the bedside multiple times that the patient was DNR/DNI and the patient had a wrist band to support this, after ~3-4 minutes we were later told his code status was unclear and felt to be full code after review of the chart with no order or mention. CPR was immediately started and the patient was then intubated*.

By this time, the room had filled with people, some blocking the doorway and halls. A nursing supervisor and physician requested several times for nonessential personnel to leave, but no one did so. Staff reported having difficulties hearing the physician's orders throughout the code because there were so many people in the room.

During the period of code status confusion, the anesthesiologist arrived in the room with the anesthesia technician and observed that "the patient was laying on his side with no rescusitative [sic] efforts being made and the technician suctioning out the mouth." She observed no chest compressions in progress. She introduced herself and asked the code team physician if he needed anesthesia's assistance. She was informed that the patient was DNR, so she was dismissed. According to her note, "since no efforts to revive the patient was ongoing, I left the patient's bedside."

The patient became pulseless 3 minutes after the Code Blue call during the time of code status confusion. Staff started chest compressions at 5 minutes after the Code Blue call, after a staff member concluded that there was no DNR/DNI order in the computer and reported to the code team that the patient was full code. The code team applied defibrillation pads on the patient at this time and administered a dose of

[13] A crash cart is a portable cart containing emergency equipment and supplies such as medications, suction devices, airways, oxygen supplies, tracheal tubes, and often a cardiac monitor with a defibrillator. It is intended to be readily available for resuscitative effort.

epinephrine. The patient was in a pulseless electrical activity[14] cardiac rhythm. Thus, there was a 2-minute delay in initiating chest compressions. The American Heart Association recommends initiating immediate chest compressions for adults suffering from sudden cardiopulmonary arrest, followed by establishing a patent airway and providing breathing. These tasks could have been performed concurrently, as there was a room full of staff and several physicians.

The staff called a second *Code Blue* after the patient was determined to be full code. The anesthesiologist was approximately 50 steps away, about to enter the staircase around the corner from the patient's room, when she heard the overhead page. She came back into the room and found the patient supine (laying face up) in the bed.

The anesthesiologist and RT continued bag-valve mask ventilation while the anesthesia technician prepared the intubation equipment. The large volume of vomit that continued to flow out of the patient's mouth created a difficult airway situation. Upon viewing the oropharynx with the laryngoscope, the anesthesiologist saw copious brown fluid completely covering the opening of the trachea, with a chunk of partially digested food in the mouth. She continued to suction the fluid and was able to insert the ET tube into the trachea on the first attempt. The intubation time was 10 minutes after the initial Code Blue call.

After the ET tube was placed, there was initially vomit in the tube, and the trachea was suctioned via the ET tube. The anesthesiologist later visually verified that the ET tube was in the proper place. The anesthesiologist inserted an orogastric tube from the mouth into the stomach and attached it to suction while staff continued suctioning the mouth. Staff reported copious amount of vomit and that there was also vomit covering the floor, bed, and some of the staff.

The presumptive cause of death was aspiration of gastric contents into the lungs. The required treatment for aspiration was rapid control of the airway, typically by intubation, to relieve and prevent further airway obstruction. The code team physician was competent to perform intubation, but he was busy managing other aspects of the resuscitation effort. The most skilled person to perform intubation was the anesthesiologist; however, she was dismissed after being told that the patient was DNR. Although soon called to return, a period of time elapsed from the anesthesiologist's initial arrival to the code to completion of intubation. Of note, the patient was being actively managed by the code team physician during this time.

While the anesthesiologist was managing the airway, the code team physician was directing the staff to administer resuscitation medications. Despite these efforts, there was no return of circulation, and the patient remained pulseless. The attending surgeon arrived at the bedside during this period, and the code team physician asked everyone in the room for feedback on stopping resuscitative efforts. The group agreed that

[14] This is a rhythm where there is electrical activity in the heart but not enough to generate blood circulation to vital organs as evidenced by the lack of pulses.

further treatment was unlikely to be beneficial and terminated resuscitative efforts after administering a last dose of medication. The patient was pronounced dead 15 minutes after the initial Code Blue call. The family obtained an autopsy from a non-VA facility. We were unable to obtain the results for review.

Issue 2: MSU Work Climate and Nurse Leadership Support

We did not substantiate the allegation that MSU staff were afraid to speak up because of a culture of bullying and retaliation on the unit. However, the MSU's lower overall AES scores suggest less than positive perceptions regarding supervisory behaviors. Of the seven supervisory behaviors measured, psychological safety—creating an environment where employees were encouraged to speak when they disagree with the decision—received the lowest score of 3.0 out of 5.0. We determined that facility managers should conduct a thorough review of the unit to eliminate behaviors that undermine effective working relationships between staff and their supervisor.

During staff interviews, we asked whether nurses received support from nursing leadership after the traumatic code event. One nurse acknowledged receiving support from supervisors, but several other staff denied receiving or being offered any support. Nursing leaders confirmed that the support provided was informal but that they made staff aware of available facility resources such as counseling from the Chaplain and Psychology Services. During interviews, some staff remained distraught over the incident. We determined that leadership needs to implement a plan for proactive employee support in response to a traumatic event.

We substantiated that the majority of nursing managers were not present in the building at the time of the incident because of a scheduled quarterly meeting outside the facility. However, a nursing supervisor was present during the code, and a unit staff nurse leader was assigned to provide supervisory coverage in the absence of the MSU manager.

Issue 3: Unprofessional Behavior by a Physician

We did not substantiate the allegation that a physician showed unprofessional behavior by berating staff participating in the patient's code in a public hallway. The facility reported that in a post code debriefing meeting, the subject physician denied the allegation and stated that the conversations were with another physician and only occurred in the patient's room during the time of the code. The physician remembered replying in a firm voice that situations concerning ambiguity in a patient's code status should never happen. During interviews, no one reported that the physician showed unprofessional behavior during or after the code.

Conclusions

We found that the facility did not respond to the patient's request to speak to facility staff regarding ADs.

We substantiated that the patient's identification wristband had the incorrect code status and clinical warnings not pertinent to the patient's current condition. The staff did not verify the code status and clinical warnings during the patient's 9-day hospital stay. One contributing factor might have been that ICU nurses were using a duplicate copy of the wristband bar code for medication administration.

We substantiated that the incorrect code status on the patient's wristband led to a delay in life-saving intervention. We concluded that code status confusion delayed chest compressions, defibrillation pad placement, and medications. The anesthesiologist was turned away and called back later, causing a delay in intubation.

The facility had already started to implement corrective actions to ensure staff verify and document patients' correct code status. In addition, the facility performed an institutional disclosure of adverse events to the patient's family and conducted a comprehensive review of the care provided for this patient in accordance with VHA policy.

We did not substantiate the allegation that MSU staff were afraid to speak up because of the culture of bullying and retaliation on the unit. However, we concluded that an evaluation of the unit is warranted based on the MSU's lower than facility overall nursing AES scores on supervisory behaviors. Although we confirmed that nurse managers were at an offsite meeting when the patient died, we concluded that a nursing supervisor and an acting unit manager were available to support staff following the incident. Nevertheless, we also concluded that leadership needs to implement a plan for proactive employee support in response to a traumatic event.

We did not substantiate the allegation that a physician berated staff participating in the code.

Recommendations

1. We recommended that the Facility Director ensure that staff provide patients information on and assistance with completing advance directives.

2. We recommended that the Facility Director ensure that corrective action plans concerning clinical warnings, including code status, on patients' wristbands are fully implemented and that managers monitor compliance.

3. We recommended that the Facility Director instruct nurse managers to conduct an inspection and ongoing monitoring of all inpatient units to ensure nurses do not make copies of wristbands for medication administration.

4. We recommended that the Facility Director conduct an evaluation of the medical-surgical unit to determine if there are issues undermining psychological safety at the work place and take action to address those issues.

5. We recommended that the Facility Director develop and implement a plan for employee support following traumatic events.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: June 8, 2015

From: Director, Sierra Pacific Network (10N21)

Subject: Healthcare Inspection – Delay in Emergency Airway Management and Concerns about Support for Nurses, VA Northern California Health Care System, Mather, CA

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

Director, Management Review Service (VHA 10AR MRS OIG Hotlines)

1. Thank you for providing the opportunity to the Northern California HCS leadership team to review the draft document.

2. The facility has developed a very robust process to ensure systems are in place to correct all of the findings from this review.

3. If you have any questions regarding the report, please contact Terry Sanders, RN, Associate Quality Manager for VISN 21 at (707) 562-8370.

Sheila M. Cullen

Attachments

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: June 4, 2015

From: Director, VA Northern California Health Care System (612/00)

Subject: Healthcare Inspection – Delay in Emergency Airway Management and Concerns about Support for Nurses, VA Northern California Health Care System, Mather, CA

To: Director, Sierra Pacific Network (10N21)

Director, Management Review Service (VHA 10AR MRS OIG Hotlines)

I wish to extend my thanks to the Office of the Inspector General (OIG) for conducting a professional review of the above named incident. The recommendations contained in the report have been reviewed. Attached are the facility responses addressing each recommendation.

Sincerely,

for

David Stockwell, Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that staff provide patients information on and assistance with completing advance directives.

Concur

Target date for completion: June 30, 2015

Facility response: Upon admission, admission clerks are continuing to screen patients for Advance Directives (as was done on this patient). The Social Work Supervisor has instructed the inpatient Social Workers to prioritize daily requests for advance directive education (generated by the admission screenings) to include providing education and assistance with completing advance directives starting June 1, 2015. Social workers are providing weekend coverage, including advance directive educational services as well, effective October of 2014. Chief, Social Work Service, will monitor for compliance and report results to the Executive Quality Board (EQB) and Quality Management. Target 90%.

Recommendation 2. We recommended that the Facility Director ensure that corrective action plans concerning clinical warnings, including code status, on patients' wristbands are fully implemented and that managers monitor compliance.

Concur

Target date for completion: Completed January 30, 2015

Facility response:

a) The Chief Nurse, Acute Care, was instrumental in revising the Bio Point software. The software was upgraded to include the Registered Nurse (RN) initials, name of the person that printed the wristband, and verification of code status with the Physician order in CPRS.

b) All staff, including clinical & administrative personnel in the acute care units was educated on the new process effective January 30, 2015. Target met with 149 of 149 staff trained (100%). In addition, a power point presentation was developed and is available as a resource to all current and new staff with a step by step instruction.

c) Chief Nurse, Acute Care, instructed the Nurse Managers on their respective units to conduct ongoing monitoring beginning January 3, 2015 to assess for errors in the clinical warnings on the printed wrist bands (i.e., DNR, isolation, etc.). Monitoring on all units has met or exceeded the 90% target.

Numerator = number of patient's audited with a correctly printed wrist band reflecting accurate clinical warnings.

Denominator = number of patient's audited.

Data by unit:

Unit	January 2015	February 2015	March 2105	April 2015	May 2015
MSU	14/15 = 90%	12/12 = 100%	12/12 = 100%	12/12 = 100%	8/8 = 100%
BHICU	10/10 = 100%	12/12 = 100%	12/12 = 100%	12/12 = 100%	6/6 = 100%
TCU	12/12 = 100%	12/12 = 100%	12/12 = 100%	12/12 = 100%	8/8 = 100%
ICU	8/8 = 100%	12/12 = 100%	12/12 = 100%	12/12 = 100%	6/6 = 100%

d) VA NCHCS instituted a change in the daily gains and losses report. An automatic report is run at midnight; to verify that all inpatients have a code status. Any patient that is captured in this report that needs a code status is addressed for corrective action at the service chief level. In addition, this is also reported during morning report to the Director and Chief of Staff.

Recommendation 3. We recommended that the Facility Director instruct nurse managers to conduct an inspection and ongoing monitoring of all inpatient units to ensure nurses do not make copies of wristbands for medication administration.

Concur

Target date for completion: Completed February 27, 2015

Facility response: Chief Nurse, Acute Care, and Assistant Chief, Benefits & Data Management Service (BDMS) instructed the nurses and clerks not to make copies of the wristbands. Nursing & BDMS leadership concurred to restrict the printing option of wristbands to select trained, authorized personnel. Bio Point software change was implemented to identify unauthorized personnel. Added feature assures only authorized personnel print wristbands. An ongoing monitoring process was implemented in February, 2015 of all inpatient units to monitor for duplication of wristbands and compliance exceeded the target of 90%.

Numerator = number of patient's audited without a duplicate wrist band having been printed for medication administration.

Denominator = number of patient's audited.

Data by unit:

Unit	February 2015	March 2105	April 2015	May 2015
MSU	4/4 = 100%	6/6 = 100%	5/5 = 100%	3/3 = 100%
BHICU	3/3 = 100%	5/5 = 100%	6/6 = 100%	4/4 = 100%
TCU	4/4 = 100%	6/6 = 100%	5/5 = 100%	6/6 = 100%
ICU	4/4 = 100%	5/5 = 100%	3/3 = 100%	4/4 = 100%

Recommendation 4. We recommended that the Facility Director conduct an evaluation of the medical-surgical unit to determine if there are issues undermining psychological safety at the work place and take action to address those issues.

Concur

Target date for completion: September 30, 2015.

Facility response: The Associate Director, Patient Care Services (ADPCS) assigned a new Chief Nurse, Acute Care, for the inpatient units effective February, 2015. The Chief, Nurse Acute Care, Nurse Managers & Assistant Nurse Managers, make rounds on all three shifts to promote engagement and encourage staff to speak up regarding any issues on their respective units. This allows visibility and availability of nursing leadership on all shifts. Chief Nurse, Acute Care has included articles on emotional intelligence and psychological safety in the "Huddles" and the staff meetings. Chief Nurse also uses the principles of the Civility, Respect, and Engagement in the Workplace (CREW) in the regular staff meetings and unit huddle boards to improve teamwork and communication.

Recommendation 5. We recommended that the Facility Director develop and implement a plan for employee support following traumatic events.

Concur

Target date for completion: September 30, 2015.

Facility response: VA NCHCS has designated a Mental Health Professional as the SME and the program manager for Critical Incident Stress Management (CISM). Selection of Team members for the Disaster Mental Support Professionals was completed in May. Northern California Health Care System PS-001/EBD-14, Disaster Mental Health Support Plan dated January 24, 2013 is currently under review and will be revised by August 31, 2015.

Appendix C

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Yoonhee Kim, PharmD, Team Leader Daisy Arugay, MT Jerry Herbers, MD Jovie Yabes, RN Amy Zheng, MD Jackelinne Melendez, MPA, Management and Program Analyst

Appendix D

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