



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Questionable Cause of Death VA Puget Sound Health Care System Seattle, Washington

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Executive Summary

The purpose of this inspection was to determine the validity of the following allegations regarding the death of a patient at the VA Puget Sound Health Care System (VAPSHCS) in Seattle, WA:

- The patient’s death was caused by equipment failure and not aspiration pneumonia.
- Staff did not communicate to the complainant that the patient “choked” and had to be suctioned prior to his death.
- The physician did not accurately annotate the cause of death (COD) on the official death certificate.

We substantiated that there was a nonfunctional suction machine, but we could not confirm whether the delay in clearing the patient’s airway was a contributing factor in his death. Progress notes clearly documented the patient’s declining condition prior to the equipment failure. We determined that community living center (CLC) nurse managers needed to clarify suction equipment procedures, assess staff competency with suction equipment, and conduct regular checks to ensure that suction equipment is functional. We also determined that an incident report should have been filed for the equipment failure event.

We substantiated that clinical staff did not communicate to the complainant that the patient experienced aspiration and had to be suctioned shortly before his death. We determined that CLC staff should have discussed this event with the complainant and completed a clinical disclosure note in the medical record.

We did not substantiate an inaccurate annotation of the COD (aspiration pneumonia and Alzheimer’s disease) on the death certificate. We determined that miscommunication could have been avoided had the physician explained aspiration pneumonia more completely and ensured that the complainant fully understood the explanation.

We also determined that agency staff competencies should cover the specific care needs of the long-term care patient population. CLC nurse managers did not validate agency staff competencies for the long-term care patient population.

We recommended that VAPSHCS managers take action to ensure functionality of suction equipment, reinforce compliance with requirements related to incident reporting and disclosure of unexpected events, ensure clinicians explain medical conditions in simple terms and elicit verbal understanding from the patient and/or family, and validate agency staff competencies related to CLC patients. The Veterans Integrated Service Network and VAPSHCS Directors agreed with the findings and recommendations and provided an acceptable action plan.



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

TO: Director, Veterans Integrated Service Network 20

SUBJECT: Healthcare Inspection – Questionable Cause of Death, VA Puget Sound Health Care System, Seattle, Washington

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections reviewed allegations regarding the death of a patient in the community living center (CLC)¹ at the VA Puget Sound Health Care System’s (VAPSHCS) American Lake (AL) Division. The purpose of this inspection was to determine the validity of the following allegations:

- The patient’s death was caused by equipment failure and not aspiration pneumonia.
- Staff did not communicate to the complainant that the patient “choked” and had to be suctioned prior to his death.
- The physician did not accurately annotate the cause of death (COD) on the official death certificate.

Background

The OIG received a complaint from the wife of a patient (the complainant) alleging that the cause of her husband’s death in June 2008 was due to equipment failure and not aspiration pneumonia.² At the time of his death, clinicians told the complainant that her husband had passed away peacefully, and she was satisfied with that explanation and the care provided. However, in July, the complainant received an anonymous phone call stating that her husband had actually died as a result of a nonfunctional suction machine when he aspirated (“choked”)³ as he was being fed by an agency nurse. As a result, the complainant felt that she had been lied to because CLC staff did not inform her of the

¹ A CLC (formerly called a nursing home care unit) provides compassionate, person-centered care in a safe and homelike environment to eligible veterans who require a nursing home level of care.

² Pneumonia is an inflammation of the lung caused by an infection. Aspiration pneumonia is a lung infection caused by inhaling stomach contents, food, or mouth secretions. It occurs most often in patients who have difficulty with their swallowing or gag reflex. The gag reflex keeps material from entering the lungs and causing infection.

³ To aspirate is to draw in food or gastric contents into the lungs while inhaling.

aspiration and equipment failure incidents. In addition, the complainant felt that the physician did not properly annotate the COD on the death certificate. The death certificate listed aspiration pneumonia and Alzheimer's disease as the COD.

The VAPSHCS is a two-division tertiary facility located in Seattle and Tacoma, WA. It has 504 beds and 3,355 employees. In fiscal year 2008, the medical care budget was approximately \$483 million. The VAPSHCS is part of Veterans Integrated Service Network (VISN) 20.

Scope and Methodology

We interviewed the complainant by phone. We conducted a site visit at the VAPSHCS's AL Division in August 2008 and interviewed CLC nursing staff and managers; a physician; and a Supply, Processing, and Distribution (SPD) employee. We were unable to reach the involved agency nurse despite repeated attempts to contact her. We reviewed documentation, including the patient's medical records and death certificate, staff training and competency records, and equipment maintenance reports. The scope of our review was limited to the allegations made by the complainant.

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

Inspection Results

Case Review

The patient was a male veteran in his late 70's who was diagnosed with Alzheimer's disease in 1999. In 2004, he was admitted to the VAPSHCS's AL Division's CLC Dementia Special Care Unit. His past medical history included aspiration pneumonia secondary to Alzheimer's disease, dementia, and upper gastrointestinal bleed. The patient experienced a gradual decline in health during his hospitalization of more than 3 years. At the time of admission, his wishes for "Do Not Resuscitate" were made known. His plan of care documented that he was non-ambulatory, totally dependent for his activities of daily living, and frequently unresponsive to verbal stimuli.

In early June 2008, the patient had three episodes of vomiting dark secretions and was taken from the CLC to the emergency room for evaluation. Clinicians ordered diagnostic blood and radiology tests. The patient's white blood cell count was slightly elevated at 13,700 (normal range is 4,000–10,000), and his abdominal x-ray showed signs of left upper quadrant ileus (obstruction). Clinicians discussed his condition with the complainant, and the plan was to treat him conservatively on the CLC.

The next day, the patient experienced three additional episodes of vomiting dark secretions, one of which tested positive for blood. Clinicians monitored the patient's

condition, documented his steady deterioration, and communicated treatment and care changes to the complainant. A nurse documented that the patient was "...making moaning and groaning sounds. Patient continues to be non-verbal...LS [lung sounds] bilaterally coarse. Audible gurgling sounds noted...."

The following morning, the physician noted that the patient continued to deteriorate. The physician's assessment was "Likely aspiration pneumonia. UGI [upper gastrointestinal] bleed." The physician spoke to the complainant and documented that care would concentrate on comfort measures only. At approximately 1:00 p.m., while attempting to take fluids orally, the patient choked and vomited black colored material. A nurse did suction the patient and cleared his airway, but within minutes, his respirations ceased. The patient was pronounced dead at 1:05 p.m.

Issue 1: Equipment Failure

We substantiated that equipment failure occurred due to a nonfunctional suction machine, but we could not confirm whether the delay in clearing the patient's airway was a contributing factor in his death. Progress notes clearly documented the patient's declining condition. According to the death certificate, the COD was Alzheimer's disease and aspiration pneumonia. The providers we interviewed stated that the delay in suctioning the patient did not hasten or cause his death. Because the patient's death was expected and imminent, no autopsy was performed.

On the morning of the patient's death, the registered nurse (RN) noted that the filter and connector tubing were missing from the suction machine at the patient's bedside. The RN contacted SPD for replacement parts. SPD staff verified that they received a request to replace the missing parts but stated that urgency was not communicated at that time. Later that day, around 1 p.m., the patient aspirated while being given liquids by the agency licensed practical nurse (LPN).⁴ The RN was summoned and after realizing that the replacement parts for the suction machine had not arrived from SPD, obtained the backup machine from the dining room (approximately 60 feet away from the patient's room) and suctioned the patient.

For patients on aspiration precautions, the standard of practice is that suction machines be readily available at the bedside and fully operational. It appeared that a combination of unclear procedures and lack of competence resulted in the presence of the inoperable machine at the patient's bedside. The tubing and filter should not have been removed, the inoperable machine should have been replaced immediately, and the LPN should have ensured that the machine was working before feeding the patient. CLC nurse managers needed to clarify suction equipment procedures, assess staff competency with

⁴ This individual was contracted to perform nursing assistant duties at the AL Division for 13 weeks beginning April 2008.

suction equipment, and conduct regular checks to ensure functionality of suction equipment.

Also, we did not find a written incident report for this equipment failure. Veterans Health Administration (VHA) policy requires the reporting of system vulnerabilities so that a facility can take appropriate actions to decrease the chances that this type of incident could recur. Nurse managers needed to reinforce compliance with incident reporting requirements.

Issue 2: Communication

We substantiated the allegation that staff did not discuss with the complainant that the patient aspirated and had to be suctioned prior to his death. Clinicians told us that their immediate concern at the time was to not burden the complainant with unnecessary information that could cause further grief. While it is unclear whether the patient's death was hastened, the presence of a nonfunctional suction machine at the patient's bedside resulted in a delay in clearing the patient's airway. As a result, during our interview with the complainant, she felt that CLC staff lied to her and covered things up. Clinicians should have openly discussed the incident with the complainant and completed a clinical disclosure note in the medical record.

Studies have shown that patients' and families' reactions to incidents are influenced both by the incident itself and how the incident is handled.⁵ Discussing incidents openly with patients and family members is consistent with VHA's core values of trust, respect, excellence, commitment, and compassion. Had CLC staff informed the complainant of the incident at the time of or immediately after the patient's death, the anguish and anger the complainant experienced after hearing of this incident from an anonymous caller could have been alleviated.

Consistent application of clinical discussion and disclosure of incidents, including honest discussion of what happened and explanation of what will be done to prevent future incidents, will enable the VAPSHCS to maintain a positive and trusting relationship with patients and families. Open discussions promote patient safety by encouraging clinicians to seek system improvements that minimize the likelihood of recurrence. VAPSHCS managers needed to reinforce compliance with disclosure requirements.

Issue 3: Death Certificate

We did not substantiate the allegation that the physician inaccurately annotated the COD on the death certificate. Both aspiration pneumonia and Alzheimer's disease are documented in the medical record. In June, the complainant had contacted the physician

⁵ Massachusetts Coalition for the Prevention of Medical Errors, "When Things Go Wrong: Responding to Adverse Events," A Consensus Statement of the Harvard Hospitals, Burlington, MA, March 2006.

who signed the death certificate and questioned pneumonia as the COD. Even after discussion with the physician, the complainant still did not accept that the patient could have died of pneumonia.

During our interview with the complainant, she stated that she found it difficult to understand how pneumonia was a cause of death because the patient had no fever, coughing, or other symptoms she associated with pneumonia. It seemed evident that she did not understand that aspiration pneumonia was a major underlying condition contributing to the patient's death. It was only after our explanation that she seemed to understand and then accept the COD. This miscommunication might have been avoided if the physician had elicited verbal understanding from the complainant when he explained the diagnosis of aspiration pneumonia to her.

Issue 4: Staff Competency

In reviewing the competency records of the nursing staff who cared for the patient, we noted that the agency LPN was assigned to perform nursing assistant duties to long-term care patients in the CLC. Although the agency had provided an acute care competency checklist for this LPN, we did not find evidence of long-term care competencies. The Joint Commission requires organizations to assess staff competencies based on the population served.⁶ VA further requires that staff must demonstrate competencies related to both the specific population and the specific services provided.⁷ Orientation for agency staff working in the CLC should require a competency assessment for the long-term care patient population and their specific care needs that includes—but is not limited to—age-specific care, aspiration precautions or prevention, and end-of-life care goals. During our site visit, CLC managers agreed and began to address this deficiency by creating a staff development coordinator position, which will facilitate consistent validation of staff competencies.

Conclusions

We concluded that equipment failure occurred but could not determine whether the delay in clearing the patient's airway was a contributing factor in his death. CLC staff did not communicate to the complainant that the patient aspirated and had to be suctioned shortly before his death or that the suction machine at his bedside was inoperable. Staff should have filed an incident report and documented clinical disclosure in the patient's medical record. The death certificate accurately listed the COD as aspiration pneumonia and Alzheimer's disease. The clinician did not ensure that the complainant fully understood the explanation of aspiration pneumonia as a COD. CLC nurse managers did not validate agency staff competencies for the long-term care patient population.

⁶ The Joint Commission, *Comprehensive Accreditation Manual for Long Term Care*, 2007, HR.3.10.

⁷ VHA Directive 2006-014; *Admission Criteria, Service Codes, and Discharge Criteria for VA Nursing Home Care Units (NHCUs)*; March 24, 2006.

Recommendations

Recommendation 1. We recommended that the VISN Director requires the VAPSHCS Director to ensure that CLC nurse managers clarify suction equipment procedures, assess staff competency with suction equipment, and conduct regular checks to ensure that suction equipment is functional.

Recommendation 2. We recommended that the VISN Director requires the VAPSHCS Director to reinforce staff compliance with requirements related to incident reporting and disclosure of unexpected events.

Recommendation 3. We recommended that the VISN Director requires the VAPSHCS Director to ensure that clinicians explain medical conditions in simple terms and elicit verbal understanding from the patient and/or family.

Recommendation 4. We recommended that the VISN Director requires the VAPSHCS Director to direct responsible managers to validate agency staff competencies related to CLC patients.

Comments

The VISN and VAPSHCS Directors agreed with the findings and recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 7–11, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

(original signed by:)

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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: September 30, 2008

From: Network Director, VISN 20 (10N20)

Subject: **DRAFT REPORT – Healthcare Inspection – Questionable Cause of Death, VA Puget Sound Health Care System, Seattle, Washington, Project Number: 2008-02620-HI-0174**

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

Thru: Director, Management Review Service (10B5)

1. Attached you will find VA Puget Sound Health Care System's response with their action and implementation plan to each of the recommendations.
2. If you have any questions regarding this response, please contact Robin Cook, Director, Quality Improvement at (206) 764-2650.

(original signed by Michael Fisher, Deputy Network Director, for:)

Dennis M. Lewis, FACHE

Attachments

Health Care System Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: September 29, 2008

From: Director (663/S-00), VA Puget Sound Health Care System, Seattle, WA

Subject: **DRAFT REPORT – Healthcare Inspection – Questionable Cause of Death, VA Puget Sound Health Care System, Seattle, Washington, Project Number: 2008-02620-HI-0174**

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

Thru: Director, Management Review Service (10B5)

VA Puget Sound Health Care System (VAPSHCS) concurs with each of the findings and recommendations in the draft report. Please find the following action and implementation plans in response to each of the recommendations.

If you have any questions regarding this response, please contact Robin Cook, Director, Quality Improvement, at (206) 764-2650.

(original signed by:)
Stan Johnson

Health Care System Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's Report:

Recommendation 1. We recommended that the VISN Director requires the VAPSHCS Director to ensure that CLC nurse managers clarify suction equipment procedures, assess staff competency with suction equipment, and conduct regular checks to ensure that suction equipment is functional.

a. Sterile Processing Department (SPD) has confirmed that 100% of suction machines are in full operating order upon leaving their department. A comprehensive test of each suction machine is conducted by SPD prior to delivery to point of service.

b. All CLC nursing staff attended a mandatory in-service held in multiple sessions on August 26, 27, and 28, 2008, where Nursing and SPD reviewed the CLC procedures and manufacturer's guide to proper setup and use of the suction machines. In addition, the presentation was reviewed to reinforce Patient Incident Reporting procedures related to equipment, as well as other incidents. Training was completed by all current on-duty staff on all shifts. For the few who could not attend the in-services, one-to-one training was provided by the Staff Development Nurse or Nurse Managers. (Only one staff member who is on extended sick leave has not completed the training.) The Staff Development Nurse and SPD staff will continue to provide this training for all returning or incoming new staff, including agency or contract staff.

c. Prior to the hotline inspection August 6–7, 2008, procedures were in place for daily checks of suction equipment by the CLC charge nurse or designee. Daily check procedures and procedures for managing non-functioning equipment were discussed and reinforced during the September 17, 2008, nursing staff meeting. All suction machines have continued to receive routine daily checks since the hotline inspection and have been found to be in operating order 100% of the time.

d. CLC Nursing leadership (Director of Nursing, Nurse Managers for CLC and Dementia Special Care Unit) held a joint meeting with SPD staff and supervisor on August 19, 2008, and agreed that SPD will respond

immediately with replacement parts or equipment when contacted about a non-functioning suction machine or other critical equipment.

Recommendation 2. We recommended that the VISN Director requires the VAPSHCS Director to reinforce staff compliance with requirements related to incident reporting and disclosure of unexpected events.

a. An Outlook message was sent by the Nurse Manager on August 11, 2008, and again September 26, 2008, to CLC staff to remind them that it is a requirement of the institution's Patient Safety Program and organizational policy to complete Patient Incident Reports for all observed actual and potential safety issues so that they may be trended and opportunities to improve identified.

b. The September 17, 2008, nursing staff meeting emphasized that Patient Incident Reports must be completed when actual or potential events impacting patient safety are observed.

c. VAPSHCS currently conducts ongoing patient safety rounds where the Director of Patient Safety and Executive Leadership talk directly with front line staff about patient safety. The topic of incident reports and their importance to the overall Patient Safety Program will be routinely included in the rounds along with emphasis on expectations and procedures for incident reporting. These rounds follow a template for questions and answers. This topic was added to the template to assure consistent attention to this issue as of September 26, 2008.

d. The Director of Patient Safety will prepare an announcement for the electronic weekly bulletin to all staff reinforcing the organizational incident reporting expectations and procedures by October 3, 2008.

Recommendation 3. We recommended that the VISN Director requires the VAPSHCS Director to ensure that clinicians explain medical conditions in simple terms and elicit verbal understanding from the patient and/or family.

a. CLC clinicians have been notified to use simple terms and elicit verbal understanding from the patient and/or family in critical situations such as this. In addition, a facility-wide reminder/training will be provided to clinicians regarding clear communication, understanding the literacy level of patients and families, avoidance of jargon, eliciting verbal feedback of understanding, etc. This will take place during the next scheduled meetings of the Medical Staff and the Clinical Executive Board.

b. Quality Improvement Service in coordination with the Chief of Staff will develop and implement a CPRS clinical disclosure template by December 1, 2008, which will be communicated to the widest clinician audience, including the Clinical Executive Board and other service line medical staff meeting attendees. Use of this template will be tracked through Quality Improvement Service and presented to the Clinical Executive Board quarterly.

c. A more effective system of debriefing after unexpected events is being designed in order to prevent miscommunication. This system will include eliciting responses to confirm comprehension and understanding. Implementation is planned for December 2008, involving the CLC's psychologist, and with emphasis on "caring for the caregiver."

Recommendation 4. We recommended that the VISN Director requires the VAPSHCS Director to direct responsible managers to validate agency staff competencies related to CLC patients.

a. A CLC nursing competency checklist specific for long-term care has been in use and was updated by the CLC Nurse Managers, approved by the Nurse Executive, and implemented immediately following the Inspector General site visit.

b. The requirement for all staff to be reviewed for competency was reiterated with CLC Nurse Managers. The requirement to validate competency for all contract staff will be monitored for the next 90 days to ensure compliance.

OIG Contact and Staff Acknowledgments

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