# Congress of the United States
## Washington, DC 20515

November 9, 2017

Mr. Robert McDivitt
Network Director
Veterans Integrated Service Network 10
11500 Northlake Drive, Suite 200
Cincinnati, OH 45249

Mr. Andrew Pacyna
Acting Director
VA Ann Arbor Healthcare System
2215 Fuller Rd
Ann Arbor, MI 48105

Dear Director McDivitt and Acting Director Pacyna:

This letter is regarding the tragic death of a veteran at the Ann Arbor VA Medical Center and a subsequent report by the U.S. Department of Veterans Affairs Office of Inspector General (OIG). The report found that a nurse mistakenly thought the veteran had a Do Not Attempt Resuscitation (DNAR) order and therefore did not attempt to revive the veteran who then passed away. The OIG recently issued a report on this tragedy and made several important recommendations. It is critical that we fully understand the actions being taken to implement the OIG's recommendations so that we can ensure that a similar tragedy never happens again.

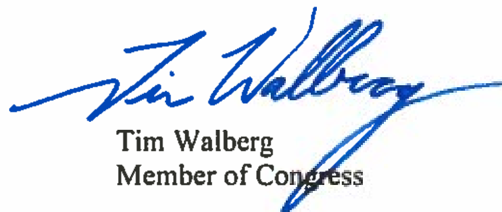
According to the OIG report, several factors contributed to the confusion surrounding the veteran's DNAR status, but it is clear that there was no standardized process to manage the communication of a patient's resuscitation status between nurses and doctors. It is even more troubling to learn that the existence of vulnerabilities related to confirming resuscitation status—particularly during worsening patient conditions—were identified by VA leadership a year prior to this incident and no remedial measures were taken.

The OIG has made six specific recommendations, including requiring staff to immediately verify resuscitation status of patients; ensuring that DNAR and the Cardiopulmonary Resuscitation orders align with one another; improving staff training and education; obtaining an independent external review; and other administrative recommendations. While you have concurred with each of these recommendations we would request a full response regarding all efforts being taking to implement these potentially lifesaving recommendations for our veterans. We would also request an estimated timeline for meeting these recommendations and to receive regular updates throughout the process.

Patient care and safety must be the top priority at the VA Ann Arbor Healthcare System. Our veterans have made great sacrifices for our nation, and we have an obligation to make sure they are properly cared for during all treatment. Thank you for your attention on this important matter and for the swift actions already being taken to ensure our veterans are receiving the highest level of care moving forward.

Sincerely,

Debbie Dingell
Member of Congress



Tim Walberg
Member of Congress

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