



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Patient Suicide VA Medical Center Augusta, Georgia

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Executive Summary

The purpose of the review was to investigate an anonymous complaint that a veteran, allegedly on suicide precautions, committed suicide while an inpatient on mental health ward 3G at Augusta VA medical center.

The subject patient was admitted to ward 3G and hung himself with a privacy curtain approximately 12 hours later. He was not on suicide precautions at the time as the admitting physician did not assess the patient to be an imminent risk for suicide, and ward staff observed the patient to be behaving and interacting normally on the ward. Despite the tragic outcome, we determined that the patient received appropriate clinical assessment and services. We also determined that the medical center immediately removed all privacy curtains on mental health units to ensure that a similar incident would not occur.

The medical center, however, did not conduct proactive risk assessments and abate environmental conditions that could endanger patients. Specific guidelines exist that require medical centers to evaluate the physical environment on mental health wards and eliminate, the extent possible, conditions which could allow patients to hurt themselves. Also, the medical center's internal review of the event did not adequately address environmental lapses, nor did responsible managers promptly notify VA's National Center for Patient Safety (NCPS) that privacy curtains on mental health units pose patient safety risks.

We recommended that managers: (i) take appropriate action in relation to responsible managers whose failure to identify safety hazards placed mental health patients at risk; (ii) assure that all managers and employees who conduct environment-of-care inspections are adequately trained and knowledgeable; (iii) follow NCPS guidance when conducting internal reviews; and (iv) notify NCPS when patient safety hazards may require nationwide alerts. The VISN and Medical Center Directors agreed with our findings and recommendations and submitted acceptable improvement plans.



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

TO: Director, VA Southeast Network (10N7)

SUBJECT: Healthcare Inspection – Patient Suicide, VA Medical Center, Augusta, GA.

Purpose

The VA Office of Inspector General's (OIG's) Office of Healthcare Inspections reviewed a complaint that a veteran, allegedly on suicide precautions (SPs), committed suicide while an inpatient on mental health ward 3G of the VA medical center (the medical center) in Augusta, GA. The purpose of the review was to determine whether the complaint had merit.

Background

The medical center is a two-division, tertiary care facility that provides medical, surgical, and spinal cord injury care at the Downtown Division, and mental health and long term care at the Uptown Division. The building that houses ward 3G was opened in 1991; ward 3G was designated as a mental health unit at that time. The medical center has a joint venture agreement with Dwight David Eisenhower Army Medical Center (EAMC) and is affiliated with the Medical College of Georgia. The medical center is part of Veterans Integrated Service Network (VISN) 7.

There are approximately 30,000 suicides in the United States annually. According to the Joint Commission, suicide ranks as the most frequently reported event requiring a retrospective error analysis, or Root Cause Analysis (RCA). From 1995–2005, patient suicide (inpatient and outpatient) has been reported to the Joint Commission 501 times, equating to 13.1 percent of all reported events. While most suicides occur in the community, a surprising number occur in hospital settings. About 1,500 (5 percent) suicides nationwide occur while patients are hospitalized for medical or psychiatric reasons.

Research shows that between 62 – 75 percent of inpatient suicides are accomplished by hanging or jumping from high places.¹ In 1998, Joint Commission reported that 75 percent² of RCAs regarding suicide received during the previous 2-year period involved hanging. The American Institute of Architects (AIA),³ Joint Commission,⁴ National Association of Psychiatric Health Systems (NAPHS),⁵ and Veterans Health Administration (VHA)⁶ have issued guidelines outlining suicide prevention strategies that include requirements to eliminate or mitigate environmental conditions that could pose safety risks to patients. In addition, Joint Commission and VHA have guidelines requiring clinical assessment, treatment, and management of high-risk patients.

In November 2006, an anonymous complainant reported that a veteran, allegedly on SPs, was able to hang himself with a privacy curtain while hospitalized at the Uptown Division. The complainant questioned whether appropriate safety precautions were taken for this suicidal veteran.

Scope and Methodology

We visited the medical center February 6–7 and March 1, 2007. We interviewed managers and other employees knowledgeable about the topics discussed. We reviewed the patient's medical record from both EAMC and the Uptown Division of the medical center. We also reviewed medical center and national policies, patient safety and environmental management records, and quality management documents. We toured ward 3G and inspected the room where the suicide occurred.

In this report we address not only the original allegation, but related clinical, environmental, and quality review issues that came to light during the course of our inspection. This review was performed in accordance with the *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Case Summary

The patient was a 55-year-old veteran with a medical history of hypertension, penicillin allergy, and recent back surgery (2006). He presented to EAMC's emergency care and treatment area at approximately 10:00 p.m. on Saturday, October 28, 2006. The patient's

¹ Yeager, K., et al. Measured Response to Identified Suicide Risk and Violence: What You Need To Know About Psychiatric Safety, *Brief Treatment and Crisis Intervention*, May 2005.

² Category includes both inpatient and outpatient suicides.

³ *2006 Guidelines for Design and Construction of Health Care Facilities*, American Institute of Architects, Washington, DC, June 2006.

⁴ *2006 Hospital Accreditation Standards*, Joint Commission on the Accreditation of Healthcare Organizations, Oakbrook Terrace, IL.

⁵ *Guidelines for the Built Environment of Behavioral Health Facilities*, National Association of Psychiatric Health Systems, 2003.

⁶ VA National Center for Patient Safety, *Patient Safety Assessment Tool*, 2006, and VA Center for Occupational Safety, Engineering, and Health.

wife was worried that the patient wanted to take his life. He was reportedly hesitant to talk about suicidal ideation and his wife did most of the talking. Because EAMC did not have an available acute mental health bed, the patient was transported by ambulance to the Uptown Division of the VA medical center for inpatient mental health admission. The patient had not previously received mental health services from the medical center.

The patient was assessed by both the medical officer of the day (MOD) and the nursing coordinator in the Uptown Division's triage unit around 12:30 a.m. on Sunday, October 29. He was noted to be alert and oriented, maintained good eye contact, and answered questions appropriately. He reported that he had never been hospitalized for psychiatric reasons and was not followed by any psychiatric clinic. He reported that his mother and brother had committed suicide in 1983 and 1997, respectively, but he denied any history of suicidal thoughts or attempts prior to this episode. He further denied drug and alcohol abuse, active thoughts of suicide or homicide, and auditory and visual hallucinations. He stated that he had difficulty sleeping, and reported having job and financial stressors.

The patient stated that as a truck driver, he was required to drive long distances with another driver and that it was difficult for him to get along with other drivers 24 hours a day on a 5-day trip. He reported problems with sleeping in the truck for which he was taking zolpidem, a sedative, without relief. In addition, he reported constant worry and feeling stressed over medical bills that he had incurred from another hospital. His wife had noticed a change in him, and the day prior to his presentation at the medical center, he had told her about his suicidal ideation.

The MOD noted an initial assessment of depression, adjustment disorder, anxiety, and suicidal ideation, and admitted him to unit 3G, a locked acute mental health unit. He was not placed on SPs or an increased level of observation. His interim treatment plan (pending evaluation by the attending psychiatrist⁷) called for individual and group therapy, as well as a revised medication regimen. The MOD ordered diazepam (an anti-anxiety medication), fluoxetine (an anti-depressant), and hydrochlorothiazide and lisinopril (for hypertension). The patient, who had a history of chronic low back pain, reported a pain level of 3 on a scale of 10. The MOD noted that the patient contracted for safety.⁸ An addendum to the MOD's assessment indicated that the patient hoped to report to work before 3 p.m. on Monday, October 30, in order to "keep his job."

After admission to 3G, a registered nurse assessed the patient and oriented him to the ward. He received medication to help him sleep. In the morning, the patient reported for breakfast and morning vital signs; he did not voice concerns or complaints. Nursing staff observed him interacting appropriately and playing cards with other patients. At approximately 10:55 a.m., he asked to use the phone and shortly after received a

⁷ Required within 24 hours of admission.

⁸ Patient's agreement to report, rather than to act on, a desire to harm himself.

telephone call from his wife. Staff did not note anxiety or agitation related to the phone call. He subsequently requested information about visiting hours and he also received a cup of juice.

Around 11:30 a.m., the patient's roommate reported to a health technician that the patient was hanging in their room. The health technician, a licensed practical nurse, and a registered nurse found the patient at the foot of the bed, the privacy curtain (which had been twisted into a fat rope) secured around his neck. His knees were bent and his feet were touching the floor. Staff removed the noose and eased the patient to the floor. The patient was cyanotic,⁹ he had no respirations or pulse, and his pupils were fixed and dilated. Staff initiated cardiopulmonary resuscitation, which was not successful. The patient was pronounced dead at 11:45 a.m.

The MOD who attempted the cardiopulmonary resuscitation contacted the patient's wife to inform her of the event. She later came to the medical center to talk with staff, but declined the offer of counseling and other services, stating that she would utilize supportive services provided at EAMC. An autopsy was conducted, and the death certificate listed the cause of death as suicide by hanging.

⁹ Bluish skin color resulting from lack of oxygen.

Inspection Results

Overall, we found that the patient received appropriate clinical assessment and services. In addition, the medical center immediately removed all privacy curtains on mental health units to ensure that a similar incident would not occur. However, we found that the medical center did not conduct proactive risk assessments and abate environmental conditions that could endanger patients. Also, the medical center's internal review of the event did not adequately address environmental lapses, nor did responsible managers promptly notify VA's National Center for Patient Safety (NCPS) that privacy curtains on mental health units pose patient safety risks.

Issue 1: Patient Suicide

The allegation was partially substantiated. While it was true that a patient with suicidal ideation hung himself while hospitalized on a locked mental health unit, he was not on SPs at the time.

Medical center policy 509-04-26/01, *Suicide Precautions* (May 3, 2004), states that any patient admitted to the medical center who "attempts a suicidal act, is suicidal in ideation or behavior, or who has a history of suicidal attempts is considered at risk for potential suicide." SPs are a treatment and management approach to optimize the safety of suicidal or potentially suicidal patients and may include orders for continuous observation or accountability checks every 15 minutes. SPs are initiated by a physician or other responsible provider given their overall assessment of the patient's condition, behavior, and history. By its very nature, suicide is difficult to predict; thus, the decision to place patients on SPs is largely based on the clinical judgment of the care provider.

The admitting MOD was board certified in internal medicine. He had functioned as an MOD at the Uptown Division about twice per month for the past 5 years and had been employed full time as a medical consultant at Georgia State and Regional Hospital, a state psychiatric facility, since 2000. While he was not a psychiatrist, he had worked with mental health patients for several years and had obtained the experience to adequately perform his duties as an MOD. The MOD completed a lengthy and appropriate assessment and told us that he did not order SPs because the patient:

- Was oriented and seemed to have decision making capacity.
- Denied alcohol or drug abuse and was not observed to be under the influence of drugs or alcohol.
- Was considered to be a low risk for suicide based on the EAMC physician's report.
- Did not have an immediate plan or intent to harm himself.
- Contracted for safety.

- Reported occasional suicidal ideation with thoughts of driving his truck into a tree or off the road. The MOD did not consider this plan to constitute an immediate risk as the patient would not have access to a truck while hospitalized.
- Had a supportive wife and home.
- Had future plans (see “future thinking” paragraph below).

We found that the MOD’s decision to forgo SPs was understandable given the description of the patient’s presentation and behavior. Based on his clinical judgment, the MOD felt that the patient was not at risk for imminent suicide.

While we found that the clinical assessment was appropriate, it is our opinion that clinical staff overly relied on the premise that “future thinking” was a protective factor in this case. Future thinking is considered a “protective” characteristic because it supposedly reflects a patient’s intent to observe or participate in a future event, and thus, indicates he does not intend to immediately harm himself. Clinical staff told us during interviews that they considered the patient’s desire to return to work the following day as evidence of his future thinking.

In this case, the patient reported that his suicide “plan” was to run his truck into a tree or off the road. Given that he was employed as a truck driver, the “means” to accomplish the plan would readily be available once he resumed employment. In addition, the patient had reported that stress from his job contributed to his presentation to the hospital. Clinicians, who had no previous treatment experience with the patient, readily accepted his desire to return to work as future thinking. It is our opinion, however, that it was too early in the patient’s treatment to judge his intent.

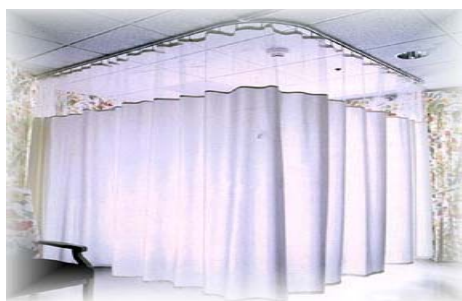
Issue 2: Environment of Care

Medical center managers are responsible for assuring the safety of high-risk patients while offering an environment that is therapeutic and inviting. This balance can pose challenges; however, patient safety always takes priority. Despite clear guidelines, managers and clinicians did not complete thorough EOC inspections, adequately evaluate environmental safety risks, test the breakaway capacity of important hardware systems, and mitigate potentially unsafe conditions on ward 3G.

Ward 3G has been a high-intensity locked mental health unit serving at-risk patients for more than 3 years. According to medical center policy, patients admitted to ward 3G include those presenting with “suicidal/homicidal thoughts, or uncontrolled psychotic symptoms such as assaultive or threatening behavior, medication non-compliance, severe depression, or deterioration in functioning.”

The AIA 2006 Guidelines for Design and Construction of Health Care Facilities [2.3-1.5 Environment of Care] states, “Patients of inpatient psychiatric [mental health] treatment

facilities are considered at high risk for suicide; the environment should avoid physical hazards while maintaining a therapeutic environment. The built environment, no matter how well it is designed and constructed, cannot be relied upon as an absolute preventive measure. Staff awareness of their environment, the latent risks of that environment, and the behavior risks and needs of the patients served in the environment are absolute necessities.” The AIA, Joint Commission, NAPHS, and VHA all reference specific requirements related to the provision of safe environments for mental health patients.



Privacy curtains are a standard component of many non-psychiatric health care settings and are commonly used in hospitals where patients must share rooms. These curtains suspend from nylon rollers that travel on aluminum tracks affixed to the ceiling.

System specifications for installation and breakaway capacity differ depending on the hospital location and patient population primarily served in the area. To promote patient safety, regulations generally require low-weight breakaway hardware on acute mental health units. According to medical center engineering staff and the privacy curtain product representative, the aluminum track should break away from the ceiling when 12-15 lbs. of weight is exerted on each nylon roller of the curtain. Thus, the installation of the track to the ceiling and the number of rollers used are key factors in determining breakaway capacity.

The privacy curtains in the patient’s room measured approximately 11 feet wide by 8 feet long and hung from 22 individual rollers spaced about 6 inches apart. The privacy curtain track was secured using a series of screws bolted directly into the ceiling. The track had been removed at the time of our visit; however, the outline of the track was still visible, and the screw holes had not been repaired. We observed that at least one screw was bolted directly into a metal air vent, and it appeared that several more screws were bolted into flashing that surrounded two ceiling-mounted access panels. These conditions would have provided a more secure anchor for the track, thus decreasing breakaway capacity.

While we could not find evidence of another suicide that occurred in exactly the same manner, we noted references associating increased risk with cubicle (privacy) curtain tracks, non-breakaway hardware, and draperies, as follows:

- The NAPHS identified cubicle curtain tracks with runners as a patient safety risk.¹⁰

¹⁰ *Guidelines for the Built Environment of Behavioral Health Facilities*, NAPHS, 2003.

- The 1998 Joint Commission safety alert (see page 9 of alert) listed non-breakaway hardware as a frequently cited contributing factor in suicides.
- AIA Environment of Care guidelines [2.3–6.2.2.2] advise that the use of [window] drapery is discouraged.

While the privacy curtain was not a window drapery, there is a clear similarity in form and function of the two privacy systems. An EOC inspection group conducting a thorough, proactive assessment according to established standards should have, at a minimum, questioned the safety of the privacy curtains.

EOC Rounds. Responsible facility managers and staff did not complete proactive risk assessments of the environment on ward 3G. Appropriate VISN and medical center staff are responsible for completing annual workplace evaluations (AWEs) and semi-annual EOC rounds specifically for the purpose of identifying environmental deficiencies requiring improvement and corrective action. Prescribed codes and standards are to be used when conducting AWEs. The ward was converted from an outpatient substance abuse clinic to an inpatient locked mental health unit more than 3 years ago. Facility Management staff told us that they conducted EOC rounds of the ward in preparation for conversion to a locked unit serving high-risk mental health patients, but did not document the results of the inspection. Despite clear and specific guidance, responsible managers and staff conducting the initial “conversion for new use rounds,” subsequent AWEs, and recurring semi-annual EOC rounds over the past 3 years did not identify these hazards:

- Towel and grab bars in the patient’s bathroom were not installed to break away under a person’s weight as required. On a locked mental health unit, non-breakaway hardware is generally prohibited as it could provide a secure anchor from which someone could hang themselves.¹¹
- Ceiling access panels were secured with regular screws that could be removed using a standard screwdriver. Guidelines specifically state that hardware should be secured using tamper-proof fasteners to prohibit improper access to potentially unsafe areas.

In addition, mental health staff members working daily on ward 3G did not identify these hazards.

Breakaway Testing. Responsible medical center staff did not test the breakaway capacity of hardware systems during AWE assessments and semi-annual EOC rounds. Responsible managers told us that they had never tested the breakaway capacity of the privacy curtains because:

¹¹ To accommodate handicapped individuals, non-breakaway hardware is permitted in up to 10 percent of rooms serving physically disabled persons. Neither the patient nor his roommate were disabled.

1. Breakaway testing is not required.
2. The nylon rollers easily disengage from the track as evidenced by maintenance staff frequently needing to reconnect them.
3. There was no history of privacy curtains posing a risk.

We disagreed with the managers' statements, as follows:

1. *Breakaway Testing Requirement.* While it is technically accurate that the applicable codes and standards do not specifically require breakaway testing, other references cite the need for breakaway capability and, as such, facility testing to document proof of that capability. In 1998, Joint Commission issued a sentinel event alert based on its review of 65 RCAs received during the previous 2-year period. The alert listed the "environment of care, such as the presence of non-breakaway bars, rods or safety rails; *lack of testing of breakaway hardware*; and inadequate security" as one of seven root causes frequently cited by facilities. In addition, the NCPS and the VA Center for Engineering, Occupational Safety and Health (CEOSH) both reference the use of breakaway fixtures throughout the locked mental health environment. The ward had originally opened as an inpatient unit, later utilized as an outpatient area, and then converted back for use as an acute inpatient unit. However, in the process of re-conversion and adaptation for inpatient use, the breakaway capacity of the privacy curtains was not tested. Without testing, managers could not be assured that fixtures would break away under a predetermined weight as intended.

2. *Release of Nylon Rollers.* While it is true that, individually, the nylon rollers are easily pulled from the track, the collective strength of the rollers is substantially greater. We tested curtain strength on two units where the privacy curtains were still in use. In the first room, we twisted the privacy curtain to make a thick rope (as the patient did). The rollers were all consolidated within an 8-12 inch linear area along the track. The curtain easily held the full weight (115 lbs.) of the inspector. In a second unoccupied room, the track partially dislodged from the ceiling under the weight of a 200 lb. man. The nylon rollers did not break free from the curtain track.

Independently, the nylon rollers that hold the curtain are not strong enough to sustain the weight of a 180 lb. man (the patient's weight). However, according to force distribution principles, force (weight) is expressed as load divided by the number of independent suspension sources. Thus, the weight of a 180 lb. load distributed among 22 rollers would require each roller to sustain about 8 lbs. of force. With 22 rollers designed to bear up to 15 lbs. each of force, the privacy curtain (mounted on a secure track) could theoretically sustain the weight of a 330 lb. person. It appears that this mechanical engineering principle was overlooked by responsible managers.

In addition, if breakaway is supposedly achieved when the track disengages from the ceiling, then the capacity of the rollers should not be a primary consideration.

3. *Safety Risk of Privacy Curtains.* The goal of proactive risk assessments is to identify potentially unsafe conditions before an adverse event occurs. Joint Commission guidelines require that, “The organization conducts comprehensive, proactive risk assessments that evaluate the potential adverse impact of buildings, grounds, equipment, occupants, and internal physical systems on the safety and health of patients, staff, and other people coming to the organization’s facilities.”

As the patient was not exhibiting signs of being actively suicidal, it is unclear what event, if any, made the patient decide to attempt suicide at that moment. Because the means were readily available, however, the patient was able to complete the suicide. For this reason, it is critical for managers to assure a safe environment that minimizes or eliminates opportunities for patients to harm themselves.

Recommendation 1.¹² The VISN Director should ensure that the Medical Center Director takes appropriate action in relation to responsible managers whose failure to identify safety hazards placed mental health patients at risk.

Recommendation 2. The VISN Director should ensure that the Medical Center Director assures that all managers and employees who conduct EOC inspections are adequately trained and knowledgeable about safety requirements for special populations.

Issue 3: Internal Review

The medical center’s internal review of the incident did not adequately address environmental lapses. RCAs are VHA’s method to evaluate system and process weaknesses that may have contributed to adverse events or close calls. Handbook 1050.1, *VHA National Patient Safety Improvement Handbook*, specifies the identification, evaluation, and reporting requirements for potential and actual adverse events. An RCA team gets to a root cause by asking “why” until it either runs out of questions to ask or decides that there are no new answers to consider. The goal of RCAs is to learn more about system weaknesses so that corrective actions can be taken and future adverse events can be prevented. The RCA process requires RCA team members to categorize root causes or contributing factors into classifications including human factors, environment/equipment, rules/policies/procedures, and other barriers.

Responsible managers did not promptly notify the NCPS that privacy curtains on mental health units pose a potential patient safety risk. The NCPS issues safety alerts to warn all VA medical centers of adverse conditions that could potentially harm patients. Since

¹² Note: After comments were received from the medical center, but before the report was published, the OIG made a policy decision to no longer have multi-part recommendations. Separate recommendations will be numbered and tracked separately; any recommendations with more than one element will not be closed until all implementation actions have been taken. This will improve the tracking and reporting of recommendations. Any disparity in this report between the numbering of the recommendations in the body of the report and in the Directors’ comments is the result of this action.

other VA medical centers could be using privacy curtains on their mental health units, it would have been prudent to promptly notify NCPS of the potential safety hazard. NCPS could then make the determination of the need to issue a national safety alert. Both the Patient Safety Officer and the Quality Managers subsequently agreed that NCPS should be notified. An NCPS safety alert was issued on February 16, 2007.

Recommendation 3. The VISN Director should ensure that the Medical Center Director requires that RCA teams follow NCPS guidance when conducting RCAs and notify NCPS when patient safety hazards may require nationwide alerts.

Conclusion

Medical center managers did not ensure a safe environment of care on ward 3G. Responsible managers and staff did not complete adequate, proactive risk assessments to identify potential hazards despite guidance available from regulatory and oversight sources. The medical center's internal review of the incident did not adequately address environmental lapses. Managers did not promptly notify NCPS of the potential hazard privacy curtains pose to high-risk patients, thus delaying issuance of the nationwide safety alert. While clinicians provided adequate care, we determined that staff overly relied on future thinking as a protective factor from suicide in this case.

VISN Director Comments

The VISN Director agreed with our findings and recommendations, and concurred with the Medical Center Director's corrective action plans. The medical center will take action to ensure that responsible managers and staff involved in EOC rounds review relevant guidelines and consult with mental health experts to ensure a safe environment. The medical center is also finalizing plans to renovate the two inpatient mental health units to assure compliance with AIA and NAPHS guidance. Employees participating on RCA teams have completed formal training or received just-in-time training, and will consult with NCPS staff as needed.

Assistant Inspector General Comments

The VISN Director agreed with the findings and recommendations, and provided acceptable improvement plans. We will follow up on planned actions until they are complete.

(original signed by:)

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

VISN Director Comments

Department of
Veterans Affairs

Memorandum

Date: MAY 23 2007

From: Director, VA Southeast Network (10N7)

Subj: Draft Report- Health Care Inspection- Patient Suicide, VA Medical Center,
Augusta, GA. Project Number 2007-00561-HI - 0234

To: Director, Management Review Office (105B)

1. Attached is Augusta's response to the Office of Inspector General (OIG) Patient Suicide Health Care Inspection visits during February 6-7 and March 1, 2007. I have reviewed the recommendations, which have been individually addressed.

2. I concur with the comments and actions taken by the Medical Center Director to improve processes at the Augusta VA Medical Center.


Lawrence A. Biro
Attachments

Medical Center Director Comments

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 report:

Recommended Improvement Action(s) 1. The VISN Director should ensure that the Medical Center Director:

- a. Takes appropriate action in relation to responsible managers whose failure to identify safety hazards placed mental health patients at risk.

Concur Target Completion Date: September 30, 2007

Appropriate action will be taken in relation to responsible managers, specifically education of responsible staff in the form of review of guidelines as noted below and through education/consultation of VA Mental Health experts to ensure safety of mental health patients.

We are currently finalizing plans for conversion of the two inpatient Mental Health units to comply with current literature (AIA and NAPHS) on the built environment for behavioral health facilities. An immediate modification to both units including removal of all privacy curtains and tracks and elimination of towel bars has been completed. Funding for the renovation and refurnishing of the units is anticipated by the end of the fiscal year.

- b. Assures that all managers and employees who conduct EOC inspections are adequately trained and knowledgeable about safety requirements for special populations.

Concur Target Completion Date: June 1, 2007

Primary staff involved in EOC rounds and inspections have been fully oriented to the current guidelines as defined by AIA and NAPHS. We will continue these efforts to ensure that all staff involved in EOC rounds and inspections are fully oriented to the current guidelines.

Recommended Improvement Action(s) 2. The VISN Director should ensure that the Medical Center Director requires RCA teams to follow NCPS guidance when conducting RCAs.

Concur Target Completion Date: June 1, 2007

This is an ongoing process. All employees currently involved in RCA teams have either completed the formal training or have been provided with just-in-time training. We will continue to assure that employees participating in future RCA teams have completed appropriate training. We will continue to utilize staff from the National Center for Patient Safety as consultants for the process.

OIG Contact and Staff Acknowledgments

OIG Contact	Victoria H. Coates, Director Atlanta Office of Healthcare Inspections (404) 929-5961
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Acknowledgments	Charles Cook Michael Shepherd, M.D.
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