Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Attempted Suicide During Treatment
West Palm Beach VA Medical Center
West Palm Beach, Florida

Report No. 11-01052-233 **July 25, 2011**

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
Telephone: 1-800-488-8244
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to review allegations that a high-risk patient was able to attempt suicide in the emergency department (ED) and again on the mental health (MH) unit at the West Palm Beach VA Medical Center (the facility), West Palm Beach, FL. The complainant also expressed concerns about staff training; poor communication with the family; and staff actions regarding an art therapy class, and the patient's transfer to a non-VA treatment center. The purpose of the review was to determine whether the allegations had merit.

We substantiated that due to lapses in carrying out suicide safety measures, the patient was able to attempt suicide twice while under the care of facility providers. We also found that facility staff did not communicate with the patient's wife in a timely manner. While not part of the allegations, we found that the facility's internal reviews of the events did not fully adhere to the National Center for Patient Safety guidelines for completion of root cause analysis.

We did not substantiate the allegation that staff received inadequate training to manage suicidal patients. We found that all staff had completed the applicable MH environment of care, suicide risk assessment, and/or suicide prevention training as required for their individual jobs.

We could not confirm or refute the allegation that staff did not respond to an event that upset the patient during an art therapy session. We confirmed that the patient was transferred from the facility ED to a non-VA MH treatment center. We found this action to be appropriate because the facility did not have any available MH beds.

We recommended that the Medical Center Director:

- Take action to ensure staff comply with 1:1 observation policy requirements.
- Conduct a review of the patient observation policy, duties, and practices on the MH unit, and take appropriate action based on the review findings.
- Train ED, MH unit, and intensive care unit providers on the methods by which they can communicate with patients' families and still be compliant with privacy laws.
- Ensure that root cause analysis reviews are conducted in accordance with the National Center for Patient Safety guidelines relative to thoroughness and credibility.

The Veterans Integrated Service Network and Medical Center Directors concurred with the findings and recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.

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

TO: Director, VA Sunshine Healthcare Network (10N8)

SUBJECT: Healthcare Inspection – Attempted Suicide During Treatment at the West Palm Beach VA Medical Center, West Palm Beach, Florida

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an evaluation to review allegations that a high-risk patient was able to attempt suicide in the emergency department (ED) and again on the mental health (MH) unit at the West Palm Beach VA Medical Center (the facility), West Palm Beach, FL. The complainant also expressed concerns about staff training and poor communication with the family. The purpose of the review was to determine whether the allegations had merit.

Background

This tertiary care facility provides a broad range of inpatient and outpatient health care services. It operates 140 acute care beds and 120 community living center (CLC) beds. Outpatient care is also provided at six community based outpatient clinics (CBOCs) in Boca Raton, Delray Beach, Ft. Pierce, Okeechobee, Stuart, and Vero Beach, FL. The facility is part of Veterans Integrated Service Network (VISN) 8 and serves a veteran population of about 177,300 throughout Indian River, Okeechobee, St. Lucie, Martin, Glades, Hendry, and Palm Beach counties in Florida.

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 2004 to 2010, patient suicide (inpatient and outpatient) has been reported to The Joint Commission 469 times (9.7 percent of all reviewed events). While most suicides occur in non-hospital settings, about 1,500 (5 percent) suicides nationwide occur while patients are hospitalized for medical or psychiatric reasons.

The Joint Commission and Veterans Health Administration (VHA) have guidelines requiring clinical assessment, treatment, and management of high-risk patients. Suicide

safety measures are a management approach to optimize the safety of suicidal or potentially suicidal patients and may include orders for continuous observation (also known as 1:1) or accountability checks every 15 minutes.

In December 2010, the complainant made allegations related to suicide safety measures, staff training, communication, and staff actions regarding an art therapy class and the patient's transfer to a non-VA treatment center. Specifically, the complainant requested that the OIG evaluate:

- Whether appropriate safety measures were implemented in the ED and on the MH unit to protect a suicidal patient.
- Why facility staff did not contact the patient's family more promptly after his ED visit and subsequent admission to an inpatient MH unit.
- Whether staff had received the necessary training to prevent this type of event from happening again.
- Why staff did not respond to an event that upset the patient during art therapy, and why staff transferred him from the facility's ED to a non-VA MH treatment center.

While not part of the allegations, during the course of this review, we identified deficiencies in the facility's internal reviews of the events.

Scope and Methodology

We conducted a site visit on February 16–17, 2011. Prior to our visit, we interviewed the patient's wife and the MH Director; reviewed local and VHA policies, directives, handbooks, and suicide risk assessment references; the patient's medical records; quality assurance documents and facility reviews; patient advocate reports; staff training records; and the American Psychiatric Association guideline on suicide assessment and prevention. While onsite, we interviewed the Suicide Prevention Coordinator and other clinical and administrative staff with knowledge of the patient's ED visit and MH care. We also toured the ED and MH unit.

This review was performed 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 is an Operation Desert Shield/Desert Storm veteran in his late forties with a primary medical history of hypertension and diabetes. He has been seen annually by his VA primary care physician at the Jacksonville Outpatient Clinic. He has been treated

monthly by fee basis[1] MH professionals for depression and post-traumatic stress disorder (PTSD) since about 2009.

Summary of Patient's Treatment During ED Visit

One day in October 2010, at approximately 11:25 a.m., the patient presented to the facility's ED complaining of suicidal ideation. Reportedly, the patient left his house earlier that day after hearing voices telling him to go out and "recon" the area. After traveling 5 hours, he saw a sign for the facility and stopped to get help.

During the triage process, the patient wrote that he felt like hurting himself and others. The ED triage nurse assessed the patient as a triage-level 3, indicating a moderate clinical urgency and the need for multiple resources. The ED nurse placed the patient on 1:1 observation, notified the ED physician (who requested a psychiatric consult), and escorted the patient to the ED treatment area where his care was transferred to the unit facilitator[2] (UF). The UF assigned the patient to a room across from the nurse's station and arranged for a health technician (HT) to provide 1:1 observation. The HT completed an electrocardiogram (ECG),[3] obtained blood samples, and applied a length of elastic tape around the patient's arm to hold the needle-stick bandage in place. The HT then covered the patient to his neck with a bed sheet for warmth. While the facility's 1:1 policy requires continuous observation "at arm's length," the HT sat outside the patient's room and observed him through the glass door. At this point, the patient had not yet been assessed by the ED nurse or physician.

Shortly thereafter, the HT noticed the patient's head leaning towards the right side of the bed and resting over the side rail, which was different from the patient's prior position. The HT found the patient with one end of the elastic bandage around his neck and the other end tied to the head rail. The HT cut the bandage and called for help, and a nurse notified the ED physician of the event.

The ED physician assessed the patient and noted that his vital signs were stable and he had not sustained any injury. The ED physician completed her evaluation and signed her note at 1:56 p.m. The on-call psychiatrist conferred with the ED physician by phone and reviewed the patient's medical record remotely. The ED physician's progress note, signed at 2:10 p.m., recommended hospitalization. The ED nurse assessed the patient and signed her note at 3:37 p.m. While the patient was deemed medically stable for admission to the MH unit, there were no MH beds available at the facility that day. The patient remained on 1:1 observation until his transfer to a non-VA MH treatment center at approximately 4:00 p.m.

Summary of Patient's Treatment During Mental Health Unit Admission

[1] Fee basis is fee-for-service care provided to eligible veterans through non-VA providers.
[2] Unit facilitators coordinate care for a group of patients; UF assignments rotate among the nurses daily.
[3] An ECG is a test that measures electrical activity of the heart.

Two days later, the patient was transferred back to the facility and admitted to the inpatient MH unit. The admission diagnoses were depression and suicidality. The treatment plan outlined inpatient treatment for mood stabilization and safety, medication management, and 15-minute safety observations.

Over the next several days, the patient attended therapy sessions, including spirituality groups, and he was compliant with the unit routine. His psychiatric medications were periodically adjusted, and while his mood remained mildly depressed, he repeatedly denied suicidal thoughts. The patient remained on 15-minute observations.

On hospital day (HD) 4, the family visited and the patient reported his medication seemed to be working; he was sleeping better, and he denied suicidal thoughts. On HD 5, the patient attended a discharge planning meeting. At approximately 10:00 p.m., the MH nurse contacted the psychiatrist to report that the patient said he had not been completely honest as he had been experiencing nightmares and hallucinations. The psychiatrist increased the psychiatric medications and added a sleep aid medication.

On HD 6, a nurse documented at approximately 6:30 a.m. that the patient's mood was depressed and that he was being observed every 15 minutes. At 12:30 p.m., another nurse documented that the patient's mood was depressed, and that he scored a 7/10 (with 10 being the highest) on the depression, anxiety, and agitation scales. The psychiatrist documented at approximately 2:00 p.m. that the plan remained the same, and that observation should continue every 15 minutes. The psychiatrist noted that if there were no changes, the patient would be discharged on HD 7. At approximately 3:30 p.m., the patient participated in art therapy group—the topic of the group was "Masks that Conceal and Reveal."

According to the 15-minute check sheet, the patient was observed either in his room or in the common area every 15 minutes from 12:00 p.m. to 7:15 p.m. At 7:00 p.m., the shift change began and nurses were receiving report while the HTs were calling patients to the nurse's station to check vital signs. At approximately 8:15 p.m., the patient was called to the nurse's station, but he did not come. A MH HT went to the patient's room and found him leaning into a sheet that had been looped through a bed frame that was standing upright. The HT removed the sheet, lowered the patient to the floor, and called for help. The patient was conscious but not responding appropriately.

Documentation reflects that when the Rapid Response Team arrived, the patient became increasingly agitated and stated, "Please just kill me now, please let me die!" He followed these statements with pleas of "Please don't harm me! Please don't kill me!" He had left a note on his nightstand saying he was being held prisoner and would not betray his country by giving the enemy any information. The patient would not answer any questions regarding his suicide attempt or current level of orientation. He was medicated with olanzapine (antipsychotic medication) and lorazepam (antianxiety

medication), placed on 2:1[4] observations, and transferred by stretcher to the intensive care unit (ICU) for further evaluation.

On HD 7, the patient was stabilized in the ICU and transferred back to the inpatient MH unit.

On HD 26, the patient was screened via telephone for the PTSD program at the Miami VA Medical Center. On HD 33, providers discharged the patient to his home while waiting for an assessment and admission to the inpatient PTSD program. The patient was admitted to the program in January 2011. The patient graduated from the treatment program in April and returned to his home.

Inspection Results

Issue 1: Suicide Safety Measures

ED Suicide Attempt

We confirmed that the patient, who was voicing suicidal thoughts, was able to attempt suicide in the facility's ED in spite of being on 1:1 observation. All interviewees confirmed that 1:1 observation requires the staff member to continuously observe the patient "at arm's length." However, the assigned HT was seated outside of the room, and at the time of the event, was entering an inventory of the patient's belongings into the medical record.

The HT told us that she received conflicting instructions about 1:1 observation; specifically, that the day shift UF expects the HT to be in the room (providing staffing allows), and the evening shift UF and ED nurse manager allow the HT to sit outside the room. When employees assigned to perform 1:1 observations do not comply with policy, patients are placed at risk.

MH Unit Suicide Attempt

We confirmed that the patient was able to attempt suicide while admitted to the facility's inpatient MH unit. The event occurred during evening shift change, which can be a disorderly time as staff attempt to complete multiple tasks and communicate pertinent information to incoming or outgoing colleagues. We also noted the following potentially contributory factors:

- The evening shift MH HT did not follow physician orders to perform 15-minute observations.
- HTs were assigned concurrent duties and did not always treat 15-minute observations as a priority.

[4] 2:1 involves two clinical people watching the patient, at arm's length, at all times.

- HT assignment sheets were not always posted or available.

On the day of the suicidal event, the day shift MH HT documented observation of the patient every 15 minutes, as required, from 12:00 p.m. to 7:15 p.m. However, there was no documentation of the 15-minute observations for this patient, or any other patient, for the next 45 minutes. Staff found the patient at 8:15 p.m., and 15-minute observations for the other patients started at this time.

For the first hour of the shift, the MH HT assigned to conduct 15-minute observations of 21[5] patients on the unit was also assigned to supervise patients wanting to shave. The HT initialed the October 18 assignment sheet acknowledging these duties. While we cannot say with certainty whether this dual assignment affected the HT's ability to conduct observation rounds that night, the MH HTs on the unit all told us they did not treat 15-minute observations as a priority in the context of their other duties.

During interviews, several HTs told us that assignment sheets were not always posted on the report room door at the beginning of each shift or signed by the HTs, as required. We confirmed this condition during two separate tours of the unit. While this lapse does not appear to have been a factor on October 18, inconsistent posting of assignment sheets and the HTs' failure to sign an acknowledgement of their duties could lead to confusion and lapses in patient safety.

We further noted that the facility's local policy on patient observation required 30-minute observations even though, in August 2010, the expectation changed to 15-minute observations. Staff generally confirmed that they were aware of and complied with the 15-minute mandate. While we do not believe that this oversight affected the patient's situation on October 18, the policy should be updated to eliminate possible confusion.

In spite of the cumbersome method by which the patient attempted suicide, we did not find any evidence that the physical environment contributed to the event. According to staff interviews and the police report (that included photos), it appears that the patient moved the wooden captain's bed into the center of the room and, using the drawer opening as leverage, pushed the bed into an upright position with the headboard resting on the floor and the foot of the bed facing the ceiling. The patient was then able to thread a sheet through some small openings at the top of the metal bed frame. The MH HT observed the patient standing on the headboard and leaning forward with his neck placed into a sheet, which produced a strangulation effect.

The Mental Health Safety Inspection Team conducted a risk assessment in October 2010 as required by guidelines.[6] The team determined that the wooden captains' beds met

[5] According to unit policy, all patients are to be observed at least every 15 minutes. There were 24 patients on the unit that night; however, 3 patients were on 1:1 observation being provided by other staff.
[6] Mental Health Environment of Care Checklist for Sleeping Rooms (section 7.2.13.2.3); *Beds in Units Treating Suicidal Patients*, version dated August 30, 2010

criteria for beds in locked MH units because they were not mechanical or electrical beds. The captains' beds weigh 163 lbs each, have rounded corners, and are flush to the floor, making them difficult to pick up or move.

Given the patient's physical characteristics, and the weight and shape of the bed, it is difficult to comprehend how he could have independently lifted the bed on to its end. A UF told us that he and two HTs were able to do this only with considerable effort.

Issue 2: Communication

We substantiated the allegation that the facility did not notify the patient's wife of his ED visit and suicide attempt, his transfer to a non-VA MH treatment center, or of his admission to the facility's MH unit. In addition, facility managers did not contact the wife promptly after his inpatient MH unit suicide attempt.

The ED Director and the Chief of Medicine both told us that ED clinicians use individual judgment, based on circumstance, to determine whether family members should be contacted. They further stated that the facility was fully compliant with patient privacy laws such as the Health Insurance Portability and Accountability Act (HIPAA) at all times.

While HIPAA does protect the privacy of individually identifiable health information, it does permit a covered entity "to rely on an individual's informal permission to use or disclose protected health information for the purpose of notifying (including identifying or locating) family members, personal representatives, or others responsible for the individual's care of the individual's location, general condition, or death."

In this case, the patient was evaluated for depression and suicidality in an ED more than 250 miles from his home. While in the ED, he attempted suicide and was transferred several hours later to a non-VA MH facility. However, we found no evidence that any of the ED staff requested his permission to contact family members.

The non-VA MH treatment center notified the patient's wife that he had been transferred there, that they were monitoring his medication, and that he might be transferred back to the (VA) facility soon.

The patient returned to the facility the next day and was admitted to the inpatient MH unit. The patient's wife told us that she did not have any contact with him that day, and we could not find documentation reflecting that any facility staff member called her. On HD 2, the patient told the MH social worker that his family came to pick up his vehicle from the facility. The social worker told us she assumed the patient had had contact with his family for them to have known where to pick up the vehicle. The social worker gave the patient a telephone calling card, and he contacted his wife the same day.

On HD 4, the wife came to visit the patient on the MH unit. The complainant's letter indicates she interacted with facility staff on this day, but the medical record did not reflect any communication between staff and the wife. On HD 5, the social worker met with the wife at the patient's request and discussed his medication regimen, the event in the ED, and tentative discharge plans.

The patient attempted suicide on HD 6, sometime between 7:15 and 8:15 p.m., and was subsequently transferred to the ICU. However, clinical staff did not notify the wife of the event or ICU admission. The wife learned of the event the following morning when her cousin, a facility employee, called her. The social worker contacted the patient's wife at approximately 2:55 p.m. on HD 7to discuss the attempted suicide event from the previous day.

Overall, we found minimal evidence that facility providers proactively contacted the patient's wife to communicate important clinical information. In fact, a majority of the contacts were initiated by the wife or occurred because she was visiting her husband. Unless the patient specifically instructed staff otherwise, it would have been appropriate for staff to notify the wife (with the patient's consent) when the patient attempted suicide, transferred to the non-VA MH facility, and was admitted to the facility.

Issue 3: Staff Training

We did not substantiate the allegation that staff did not receive adequate training to manage suicidal patients. All VHA employees are required to complete basic suicide prevention training. However, some employees are required to complete more specific training based on their work locations and clinical disciplines. We reviewed the training records of nurses and HTs assigned to the patient during his ED visit in October and during the inpatient MH unit event. We found that all staff had completed the applicable MH environment of care, suicide risk assessment, or suicide prevention training as required for their individual jobs.

Issue 4: Staff Actions

Art Therapy Class

We could not confirm or refute the allegation that staff did not respond to an incident that upset the patient during an art therapy session in October. The wife reported that she spoke with her husband that night, and he was upset because the art therapist made him feel like an "idiot" because she could not answer how the masks they were painting would do anyone any good.

The art therapist's progress note from the group session read, "Individual Response: This patient participated fully in the art therapy directive and interacted appropriately with others." The art therapist told us that she did not recall any negative reactions or exchanges during that group, but did confirm that the mask-making class sometimes

provoked emotions among class participants. We found no evidence in the medical record that the patient complained to any facility staff that the art therapy session upset him.

Patient Transfer

We confirmed that the patient was transferred from the facility ED to a non-VA MH treatment center; however, we found this action to be appropriate as the facility did not have any available MH beds. The patient was transferred back to the facility 2 days later.

Issue 5: Internal Review Process

The facility's internal reviews of the incidents did not fully adhere to the National Center for Patient Safety (NCPS) guidelines for completion of RCAs. 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*, dated March 4, 2011, 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 may be taken and future adverse events may be prevented.

The facility conducted RCAs on both suicidal events as required. We learned that the Patient Safety Manager (PSM) was relatively new in her role, and these were the first RCAs she conducted. We had the following concerns about the potential credibility and thoroughness of the RCAs:

- The RCA team compositions were not adequate to ensure impartiality. The teams included the nurse managers for the ED and the inpatient MH unit, respectively. RCAs are intended to be an impartial fact-finding of the event. Because the teams were small, the nurse managers (who had responsibility over the areas reviewed) could have intentionally or inadvertently influenced the findings of the RCA.
- Corrective actions were not always measurable, or in some cases, the outcome measure field was left blank.
- The RCAs did not include any literature reviews or other references supporting their conclusions.
- The list of staff members interviewed was not comprehensive in that it did not include all clinical staff with responsibility for the patient's care on the days in question.

- The RCA did not recommend updating of the facility's policy[7] requiring 15-minute observation on the MH unit, although this was an obvious deficiency.

In our discussions with her, the PSM confirmed that she learned a lot during this process and that she would do things differently next time.

Even though this was a new PSM and these were her first RCAs, we found no evidence that she was mentored through the process or that the RCAs received additional scrutiny precisely because they were being completed by a new PSM. Responsible managers and facility leadership all signed the RCAs indicating their approval of and concurrence with the content.

We also noted that a patient safety alert had not been issued at the time of our review. We contacted NCPS and the facility PSM about our concerns; a patient safety alert was issued on June 28, 2011.

Conclusions

Overall, we found that the patient received appropriate clinical assessment and services. In addition, the facility immediately sealed the drawers and bolted all captains' beds to the floor on the MH unit to ensure that a similar incident would not occur. However, we confirmed that the patient was able to attempt suicide twice while under the care of facility providers due to lapses in carrying out suicide safety measures.

The HT assigned to provide 1:1 observation of the patient in the ED was seated outside of the room at the time of the event. We also found that the inpatient MH HT did not complete observation of the patient every 15 minutes from 7:30 to 8:15 p.m. on the day he attemped suicide.

We confirmed that facility staff did not communicate with the patient's wife regarding his suicide attempts, transfer to a non-VA MH treatment center, or admission to the facility's MH unit. While privacy laws require the facility to be cautious about disclosure, it would have been appropriate for staff to ask the patient's permission to contact his wife.

The facility's internal reviews of the incidents did not fully adhere to NCPS guidelines for completion of RCAs. RCA team compositions were not adequate to ensure impartiality, oversight of the RCAs was lacking, and corrective actions were not always measurable or documented. As such, the facility could not be sure that they had identified the correct root causes or that corrective actions would be effective.

We did not identify any deficiencies related to staff training, an art therapy class, or the patient's transfer to a non-VA treatment center.

[7] MCM 548-118-163, *Patient Observation Levels*, October 25, 2009.

Recommendations

Recommendation 1. We recommended that the Medical Center Director take action to ensure staff compliance with 1:1 observation policy requirements.

Recommendation 2. We recommended that the Medical Center Director conducts a review of the patient observation policy, duties, and practices on the MH unit, and takes actions as appropriate based on the review findings.

Recommendation 3. We recommended that ED, MH unit, and ICU providers be trained on the methods by which they can communicate with patients' families and still be compliant with privacy laws.

Recommendation 4. We recommended that the Medical Center Director ensure that RCA reviews are conducted in accordance with NCPS guidelines relative to thoroughness and credibility.

Comments

The VISN and Facility Directors agreed with the findings and recommendations (see Appendixes A and B, pages 12–17, for the full text of their comments). The implementation plans are acceptable, and 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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 28, 2011

From: Director, VA Sunshine Healthcare Network (10N8)

Subject: **Healthcare Inspection – Attempted Suicide During Treatment, West Palm Beach VA Medical Center, West Palm Beach, Florida**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

Thru: Director, Management Review Service (10A4A4)

1. I have reviewed and concur with the findings and recommendations in the report regarding the above referenced healthcare inspection of the West Palm Beach VA Medical Center, West Palm Beach, FL.

2. Corrective action plans have been established with planned completion dates, as detailed in the attached report.

(*original signed by*:)
Nevin M. Weaver, FACHE
Director, VA Sunshine Healthcare Network (10N8)

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 27, 2011

From: Director, West Palm Beach VA Medical Center (548/00)

Subject: **Healthcare Inspection – Attempted Suicide During Treatment, West Palm Beach VA Medical Center, West Palm Beach, Florida**

To: Director, VA Sunshine Healthcare Network (10N8)

Thank you for your concise report and recommendations. Our actions have been added for your consideration.

(*original signed by*:)
Charleen R. Szabo, FACHE
Director, West Palm Beach VA Medical Center (548/00)

Facility 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:

OIG Recommendations

Recommendation 1. We recommended that the Medical Center Director take action to ensure staff compliance with 1:1 observation policy requirements.

Concur **Target Completion Date: July 22, 2011**

Facility's Response:

Based on recommendations outlined in the National Center for Patient Safety "TIPS" May/June 2011 issue, the WPB VA MC will implement weekly simulation modules on 06-23-11 for one month. During the simulation, trained staff (simulators) will be "admitted" as "test" patients with a diagnosis of being "suicidal with a plan" which requires 1:1 status. Unlike a real patient, the simulator will be permitted to keep a watch, pen and paper. Staff caring for the patient will document care and place orders that would be consistent with the diagnosis under the "test" patient's name. The simulator will maintain a record documenting all care delivered to evaluate compliance with 1:1 observation practice as outlined in the Observation Level policy. The simulators will utilize a standardized tool to evaluate the process from presentation through disposition, evaluating flow and identifying successes or opportunities for improvement related to observation level expectations per policy. Each simulation will have a debriefing involving QM/Patient Safety, Nursing, Mental Health, Medicine, and MAS. Upon completion, the simulation outcome report with recommendations will be presented to leadership at the PI Model Meeting on 07/22/2011.

Status: Implemented June 23, 2011

Recommendation 2. We recommended that the Medical Center Director conducts an impartial review of the patient observation policy, duties, and practices on the MH unit, and take actions as appropriate based on the review findings.

Concur **Target Completion Date: July 1, 2012**

Facility's Response:

After completing the collaboration process MCM 548-118-163, Patient Observation Levels, was posted on 04/15/2011. Revisions were made to reflect effective practices and ensure patient safety and staff accountability. Assignment Sheets have been reviewed and tailored to effectively document 1:1 and Close Observation requirements on a daily basis. Daily assignments are communicated to staff using SBAR and will be outlined on a posted assignment sheet with 1:1 assignments clearly identified. Daily assignment sheets will be maintained for three years. The Nurse Managers review the Assignment Sheets daily and copies of the Assignment Sheets for both the ED and 3C-Inpatient Psych are being submitted to the Director weekly. The ED and Inpatient Psych Nurse Managers' will use a standardized tool to review the assignment sheets to evaluate compliance with the policy. Findings will tracked and trended monthly and reported quarterly through the Nurse Executive Board up to the Performance Improvement Board for four quarters.

Status: Implemented June 13, 2011

Recommendation 3. We recommended that ED, MH unit, and ICU providers be trained on the methods by which they can communicate with patients' families and still be compliant with privacy laws.

Concur **Target Completion Date: July 6, 2011**

Facility's Response:

Medicine Service has arranged for the Privacy Officer, on July 6, 2011, to provide education to ED & ICU providers on accepted methods staff are to use to communicate with patients' families with an emphasis on privacy laws compliance. Medicine Service will also ensure that ED & ICU providers are compliant with all mandatory trainings related to the communication of patient information to family members as related to privacy laws.

Mental Health Service has arranged for the Privacy Officer, on June 28, 2011, to provide education to MH providers on accepted methods staff are to use to communicate with patients' families with an emphasis on privacy laws compliance. Mental Health Service will also ensure that MH providers are compliant with all mandatory trainings related to the communication of patient information to family members as related to privacy laws.

Status: Pending

Recommendation 4. We recommended that the Medical Center Director ensure that RCA reviews are conducted in accordance with NCPS guidelines relative to thoroughness and credibility.

Concur **Target Completion Date: June 20, 2011**

Facility's Response:

Upon review, it was determined that we followed the VHA National Patient Safety Improvement Handbook VHA Directive 1050.01 and excluded individuals directly involved in the both events. The recommendation by the OIG to exclude supervisors has been identified as an opportunity for improvement, and will be implemented in future RCA reviews.

Each RCA contained at least "one strong string" as required with corrective actions and associated outcome measures that were reviewed and determined to be measureable and quantifiable by National Center for Patient Safety. In two instances beyond the strong string, one in each RCA, there were outcome measures that were not quantifiable. One pertained to the recommended action of purchasing new equipment; regrettably, it was determined that the new equipment would not be compatible with existing equipment and therefore the action could not be implemented or subsequently measured. The second instance involved a staffing analysis that yielded ambiguous results, and therefore the outcome could not be measured or quantified.

As stated in the VHA National Patient Safety Improvement Handbook VHA Directive 1050.01, it is recommended that inclusion of consideration of relevant literature be used during the RCA process. In both cases, relevant literature was considered and reviewed, but was not entered into Web SPOT. Consideration of relevant literature reviews will be documented in Web SPOT in all future RCA's.

At the time of the RCA, the team was aware that MCM 548-118-163 Patient Observation Levels had been reviewed and revised and the 30-minute checks were changed to 15-minute checks but the MCM delineating these changes was out for collaboration. The collaboration process was completed and the Director signed the MCM which was posted on 04/15/2011 for implementation.

Status: Completed

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
Acknowledgments	Victoria Coates, LICSW, Project Leader Audrey Collins-Mack, RN, MSA, Team Leader Michael Shepherd, MD Karen Sutton, BS

Appendix D

Report Distribution

VA Distribution

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Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Sunshine Healthcare Network (10N8)
Director, West Palm Beach VA Medical Center (548/00)

Non-VA Distribution

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House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
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