Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Service Delivery and Follow-up After a Patient's Suicide Attempt
Minneapolis VA Health Care System
Minneapolis, Minnesota

Report No. 12-01760-230 **July 19, 2012**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted a review at the request of Congressman Tim Walz regarding alleged improper medication management and discharge planning practices at the Minneapolis VA Health Care System (the facility) in Minneapolis, MN.

We did not substantiate the complainant's allegations that a change in medication contributed to her husband's death by suicide, that managers improperly tried to "commit" him to a Veterans Home, or that staff told her she was not her husband's power of attorney (POA). Medical record documentation reflects that the patient's medication had not been changed. His chronic depression was attributed to his medical and mental health conditions and to his substantial psychosocial stressors. Further, the medical record does not support the allegations related to the Veterans Home or POA.

We found, however, that the Suicide Prevention Coordinator did not participate in the evaluation and ongoing monitoring of the patient, and the treatment team did not complete a suicide risk assessment at the time of the patient's discharge in February. Staff did not place the patient on the high-risk for suicide list or initiate a patient record flag (PRF), and as a result, the patient did not receive the prescribed level of monitoring and follow-up.

Clinical staff did not complete a suicide behavior report or report the patient's death by suicide in a reasonable time. The former patient safety manager learned of the suicide more than 2 weeks after the event.

While the internal review of the patient's death addressed the two questions posed by the former patient safety manager, it did not address the overall suicide risk management issues that are central to this case. Its conclusions were not always supported by the medical record, and it primarily focused on one provider rather than on the team of providers who have collective responsibility for these patients. Further, systems issues identified in the internal review had not been adequately followed up.

Facility policy did not include provisions for PRF placement except for those patients discharged from the inpatient mental health unit, nor did it include any reference to suicide safety planning requirements. Further, Spinal Cord Injury and Disorders staff were unaware of some administrative requirements for managing patients at high risk for suicide.

We made eight recommendations to improve quality of care and administrative processes related to suicide prevention. The Veterans Integrated Service Network and Medical Center Directors agreed with our findings and recommendations and provided acceptable improvement plans.

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

TO: Director, VA Midwest Health Care System (10N23)

SUBJECT: Healthcare Inspection – Service Delivery and Follow-up After a Patient's Suicide Attempt, Minneapolis VA Health Care System, Minneapolis, Minnesota

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review in response to allegations of improper medication management and discharge planning practices related to a multiple sclerosis patient at the Minneapolis VA Health Care System (the facility) in Minneapolis, MN. The review was requested by Congressman Tim Walz and the purpose was to determine whether the allegations had merit.

Background

A. Minneapolis VA Health Care System

The Minneapolis VA Health Care System is a tertiary care facility that provides primary, specialty, mental and behavioral health, extended care, and rehabilitative services. It also serves as the Spinal Cord Injury and Disorders (SCI/D) referral center for Veterans Integrated Service Network (VISN) 23. Primary and mental health care is also provided at community based outpatient clinics (CBOCs) in Rice Lake, Hayward, and Superior, WI, and in Hibbing, South Central, Mankato, Chippewa Falls, Maplewood, Rochester, and Ramsey, MN.

SCI/D Centers provide SCI/D primary care and SCI/D specialty care with a full continuum of rehabilitation, medical and surgical care, respite care, preventive services, and long-term care services.

B. Allegations

In December 2011, the widow of a veteran who was 100 percent service-connected for multiple sclerosis complained to Congressman Tim Walz about the care her husband received at the facility. Specifically, she alleged that:

- Her husband experienced personality and mood changes after facility providers changed his medications.
- The altered medication regimen contributed to his death by suicide.
- Senior facility managers attempted to commit her husband to a "Veterans Home" without her permission.
- Three facility staff told her that she was no longer her husband's power-of-attorney (POA) as the designation had been given to his [her husband's] sister.

The complainant also reported that because the VA medical center (VAMC) in Gainesville, Florida, did not promptly respond to her automobile insurance claim involving a valet parking accident, she was left without transportation for an extended period of time.

C. Medical Overview

Multiple sclerosis (MS) is a disorder of the central nervous system that affects about 400,000 people in the United States (US). Most people with MS have remitting and relapsing symptoms that include numbness or tingling, extremity weakness, bladder difficulties, and visual disturbances. Depression is also common. However, about 10 percent of these patients have primary progressive multiple sclerosis (PPMS), which means they do not have remissions. Rather, they experience a gradual worsening of their disease over time which usually affects the ability to walk. These patients may also have bowel, bladder, and/or sexual problems.[1] Veterans with MS are often cared for by the SCI/D team as they suffer from many of the same chronic conditions associated with SCI and paralysis.

Suicide is the tenth leading cause of death in the US, with nearly 100 suicides occurring each day and over 36,000 deaths by suicide each year. Among veterans and active duty military personnel, suicide is a national public health concern, with recent estimates suggesting that active or former military personnel represent 20 percent of all known suicides in the US.[2]

As part of its plans to address suicidality in veterans, the Veterans Health Administration (VHA) has implemented multiple initiatives in the past several years including: staff training; public education; outreach to veterans, families, and providers in the community; development of a national telephone crisis hotline; and funding of Suicide Prevention Coordinators (SPCs) in all VHA medical facilities. SPCs coordinate care for

[1] http://my.clevelandclinic.org/disorders/multiple_sclerosis/hic_primary_progressive_multiple_sclerosis.aspx
[2] VA Health Research & Development Service, *Suicide Prevention Interventions and Referral/Follow-up Services: A Systematic Review*, March 2012.

veterans at risk for suicide and serve as advisors to the facility staff and leadership. VHA has also provided extensive guidance to enhance clinical care for at-risk patients.

Patients admitted to VHA medical facilities are screened for suicidal ideation through the use of several basic questions. If a patient has a positive suicide screen, designated clinical staff conduct a more in-depth suicide risk assessment (SRA) to determine the presence or absence of risk factors, available coping skills, and level of suicide risk.

Once a patient is assessed to be high-risk or have a recent suicide attempt, enhanced care activities are guided by Deputy Under Secretary for Operations and Management (DUSHOM) memorandum, *Patients at High-Risk for Suicide*, dated April 24, 2008. The memo states, "It is the responsibility of the SPC in each facility to maintain a list of patients at high-risk for suicide, including but not limited to, those who have suicidal ideation and those who survived suicide attempts…" It further states, "Patients, who are admitted for hospitalization as a result of a high-risk for suicide ideation, must be placed on the high-risk list, and kept on the list for a period of at least 3 months after discharge. They must be evaluated at least weekly during the first 30 days after discharge. Other patients identified as surviving a suicide attempt … should be evaluated at least weekly for at least the next month." Typically, patients on the high-risk for suicide list also have a patient record flag (PRF) placed in their medical record to electronically alert other providers of their current risk status.

Scope and Methodology

Prior to our site visit, we interviewed the complainant; reviewed the patient's medical record, facility policies, staff training records, and VHA directives and guidance; and evaluated quality management (QM) documents. We visited the facility on March 29, 2012. We interviewed clinical employees involved in the patient's care and other personnel with knowledge of the issues involved. We were unable to interview several key employees as they had either retired, or were no longer working at the facility, or were on extended sick leave. We did not review the automobile insurance-related complaint as the issue is beyond the scope of OHI operations.

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

Inspection Results

Case Summary

The patient was a 100-percent service-connected veteran in his mid 50s with a primary medical history including PPMS, major depressive disorder, neurogenic (dysfunctional) bowel and bladder, spasticity, chronic pain, and diminished vision. He was followed by the facility's Rehabilitative Medicine Service and admitted periodically to the SCI/D unit for 2-week respites and annual evaluations. The patient's medical record reflects a history of marital discord and occasional suicidal ideation. In early Fall 2010, the patient lost his wheelchair-accessible van, home, and belongings in a flood. After the loss, he resided with his son and his son's fiancé until the time of his death by suicide less than a year later.

In mid-January 2011, the patient participated in an MS support group. The therapist documented that the patient reported ongoing depression and hopelessness, but stated he would not engage in suicidal behavior because of the impact on his family. The therapist scheduled a follow-up appointment for the next week.

Five days later, the patient was brought to a private-sector emergency room and admitted after he cut his throat in a failed suicide attempt. Documentation from the private-sector hospitalization reflects that the patient reported he intended to kill himself but realized after about 4 hours that his attempt would be unsuccessful, so he told his son's fiancé and she called 911. The patient told staff that he had been thinking about suicide a lot lately, and that "it would be the easiest way to take care of all the problems" he had. He further told them that he felt like a burden and endorsed feelings of anhedonia (loss of the capacity to experience pleasure), decreased motivation, trouble with focus and concentration, as well as hopelessness, helplessness, guilt, and worthlessness. He denied any prior history of suicide attempts. The patient initially denied any family history of psychiatric disorders but then told staff he had a brother who died after he parked his car on a railroad track and another brother who "drank himself to death." The patient was treated and released about a week later. His psychiatric medications on discharge included bupropion (150 milligrams [mg] dose once daily) and fluoxetine (40 mg dose once daily) for depression, and clonazepam (3-4 mg at bedtime) for restless leg syndrome. He was also discharged on medications for his PPMS, bowel and bladder issues, groin pain, gastroesophageal reflux disease, and high cholesterol. He expressed his intent to follow up with his providers at the facility.

Two days after discharge from the private hospital, the patient presented at the facility for a routine follow-up appointment with his long-standing SCI/D provider, a nurse practitioner (NP). The NP asked the patient about the scar on his neck, to which he

replied that it was from a recent suicide attempt when he cut his throat.[3] The patient was admitted to the SCI/D unit due to "concern for safety [related to] recent suicide attempt." The SCI/D unit staff knew the patient well from previous admissions and was better equipped than the mental health unit to manage his ongoing medical needs, such as catheter care.

Upon admission, staff completed a suicide behavior report (SBR) which reflected that the patient's stated level of intent (to complete the suicide) was "high," but the staff member's impression was that the level of intent and the lethality of approach were "moderate." Two different staff members completed suicide risk assessments (SRAs), both of which described the patient's risk level as "heightened."[4]

A mental health consult team, consisting of a medical student and attending psychiatrist, evaluated the patient on admission and documented that the patient "states he is very depressed and has nothing to look forward to." The patient denied symptoms of psychosis or of homicidal or suicidal ideation, but admitted feeling "numb," reporting "I don't feel anything." He was found to be alert and oriented with fair insight and judgment. The psychiatrist diagnosed major depressive disorder secondary to PPMS, and noted severe psychosocial stressors including "progressive neurological condition, increasing dependency, marital stressor, lost his house/assets in floods." The psychiatrist assigned a GAF score[5] of 20-25. The consulting psychiatrist initially recommended an increase in fluoxetine to 30 mg daily;[6] weekly psychology/therapy sessions; recreational therapy to increase pleasurable activities and social interaction; social work assessment of transportation, housing, and financial issues; and assessment of physical and cognitive deficits. The psychiatrist did not believe the patient required 1:1 (direct) observation at that time.

On hospital day (HD) 2, the patient's SCI/D provider documented that the patient appeared more "calm and animated." She noted the need to include the family in discharge planning in order to address his multiple issues. Progress notes over the next 2 weeks reflect that the patient participated in physical and occupational therapy activities; regularly visited the fitness center; attended art therapy and adaptive yoga and relaxation groups; and participated in supportive therapy with the psychologist, chaplain, and social worker. He also underwent a neuropsychological evaluation on HD 14, which had a primary finding of higher-level thinking deficits.

[3] The NP did not have access to the private-sector hospital's records until February 8.
[4] Heightened risk is defined by the facility as an acute or elevated level of risk, but protective factors influence safety from imminent risk.
[5] GAF score is the Global Assessment of Functioning. In this case, scores of **21 - 30** indicate an inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends).
[6] There was initial confusion about the patient's dose which was clarified and he was continued on his previous fluoxetine dose of 40 mg daily.

On HD 17 the SCI/D social worker arranged a family meeting which was originally planned to include the patient's siblings. His wife objected and the patient, wanting to avoid the stress this would create, had the social worker withdraw the invitation to his siblings. The patient, his wife, and their children were involved in the meeting.

On HD 20 the treatment team met with the patient and his family for a discharge planning conference. The patient elected to return to his son's home with Adult Day Health Care (ADHC) support. The patient was discharged on HD 21 with no acute concerns regarding his depression. There was no documentation of his suicide risk at that time. He was scheduled for a CBOC mental health appointment on post discharge day (PDD) 20 (which was later moved up 3 days), and MS support group on PDD 23. Also, his home health care services were reactivated. At the time of discharge, the ADHC referral, hand cycle, hand controls for his car, transportation, and financial concerns were being addressed but were still pending. His discharge psychiatric medications included bupropion (150 mg dose once daily) and fluoxetine (40 mg once daily) for depression, and clonazepam (3 mg at bedtime) for restless leg syndrome. He was also discharged on medications for his PPMS, bowel and bladder issues, groin pain, gastroesophageal reflux disease, and high cholesterol. Progress notes reflect that he was independent in his activities of daily living (e.g. bathing, dressing, toileting), was self-catheterizing[7] for bladder care, and was exercising his upper extremities with 1-pound hand weights. He could transfer independently and ambulate short distances with a rollator (walker with wheels and hand brakes).

A nurse and a social worker contacted the patient on PDD 1 and 2, respectively. On both days, the patient reported feeling okay and expressed no problems or concerns.

During a Neurology Clinic appointment on PDD 7, the patient complained of fatigue, attributing it to his need to self-catheterize every 4 hours at night, and to bilateral legs spasms that also kept him awake. The neurologist described the patient's mood as "very depressed," noting that the patient said his mood had continued to decline since losing all of his belongings in a flood. The neurologist prescribed baclofen for muscle spasms.

The SCI/D psychologist contacted the patient on PDD 9 and wrote that he (the patient) reported his mood continues to be "a lot better." The patient agreed to a follow-up telemental health appointment with the psychologist the following week. During the telemental health appointment, the patient reported that he was generally doing well and was getting out of the house. ADHC had not yet started and the patient reported high levels of stress related to finances and a concern about his benefits being withdrawn. The patient described his mood as "pretty good" and denied any suicidal ideation or passive

[7] A urinary catheter is inserted into the bladder via the urethra, which allows urine to drain freely from the bladder into a collection bag.

thoughts of death. The patient was scheduled for follow-up at the MS Discussion Group at the facility on PDD 23.

On PDD 17, the CBOC mental health nurse noted that the patient seemed "slightly depressed but cooperative...appeared positive, yet guarded." The appointment was limited as the family stated they had to get to the airport. The patient agreed to continue his medications and return for follow-up in 4 weeks.

On PDD 21, the social worker documented she received a voice mail from the daughter stating that the patient was going to be leaving for Florida soon and that the length of time he would be gone was unknown.

On PDD 39, the patient and his wife went to the Gainesville VAMC emergency department for catheter-related issues. A Foley catheter was inserted. On this date, the wife also contacted the facility's SCI/D clinic nurse and requested additional catheter-related supplies.

On PDDs 40 and 45, and on PDDs 51 and 67, the facility SCI/D clinic nurse spoke with the patient's wife and addressed her concerns about medications and catheter-related supplies. On PDDs 64 and 65, the nurse spoke directly with the patient about medication issues. None of these calls included a discussion about the patient's mood or mental health status.

In mid-May, the patient's wife called the facility SCI/D social worker and reported that her husband "was missing," and alternately accused VA staff and the patient's sisters of "taking him." The social worker assured the wife that VA staff have no authority to "take" patients. The social worker then notified Gainesville VAMC staff of the unusual telephone call. Gainesville VAMC documentation reflects that the local police were notified and that they (the police) ultimately were satisfied the patient was not missing.

The next day, at approximately 2:00 a.m., the patient presented to the Gainesville VAMC emergency department for catheter-related issues. The progress note from this visit did not include any discussion of the event the previous day; however, the patient stated that he had no urgent needs or mental health concerns requiring social work intervention at that time.

Four days later, the wife left a message for the facility SCI/D clinic nurse. When the nurse returned her call, the wife reported that her husband was so overwhelmed he crawled into a shed because he was ashamed of the constant [urinary catheter] leaking. The nurse reviewed the procedures for opening the valve to assure that the urine flows into the night bag. The nurse notified the patient's provider of the call but no follow-up was documented. It is unknown whether the wife was referring to the missing patient event during her call four days after her report, or whether they were two separate events.

The wife called back to the SCI/D clinic nurse 6 days after she reported her husband missing and apologized for being upset during her call three days earlier. It appears that the patient returned to Minneapolis from Florida sometime in late May.

In early June, the wife spoke with the SCI/D case manager about scheduling the patient's annual physical evaluation and making arrangements for staying at the Fisher House (provides temporary housing arrangements for families) in July. The wife again contacted the SCI/D clinic nurse in mid-June regarding catheter-related issues, and orders were sent to the home health agency.

In early July, the SCI/D case manager contacted the patient's wife to coordinate the patient's annual physical examination. During this contact, the wife told the case manager that the patient had died several weeks earlier.

Documentation from a private-sector burn unit reflected that the patient was admitted the day before he died with extensive thermal burns over 65 percent of his body. The patient was noted to be alert and able to participate in decisions. With his family in agreement, he elected to be placed on comfort measures only. The death certificate listed suicide by self-immolation (i.e., setting oneself on fire) as the cause of death. The patient's body was cremated.

Issue 1. Medication Management

We did not substantiate the allegation that the patient experienced personality and mood changes after facility providers changed his medications or that the altered medication regimen contributed to the patient's suicide. The complainant alleged that her husband was prescribed certain medications while hospitalized at the private-sector hospital after his January suicide attempt, and that facility providers changed those medications after he was admitted. The complainant was not able to identify which medications she thought had been changed, nor was she able to describe specifically what personality and mood changes occurred.

We compared the discharge medication list from the private-sector hospital with the patient's medication regimen after his admission to the facility and found that facility providers continued the same medication regimen during his VA hospitalization. While the medical record reflected that the patient continued to be depressed, this was attributed to the patient's medical condition and significant life stressors, not to medication changes or adjustments. Further, it is unlikely that medication changes in late January and early February would have contributed to his death by suicide 5 months later.

Issue 2. Discharge Planning and POA Concerns

We did not substantiate that senior facility managers attempted to commit the patient to a "Veterans Home" without his wife's permission. The treatment team met with the patient and his family in mid-February to discuss discharge planning options. At that time, the social worker suggested short-term nursing home placement as a possible option given the patient's medical condition and increasing assistance needs. The patient was competent to make his own discharge planning decisions and ultimately elected to return to his son's home with community-based social and medical supports. Because the patient had decision-making capacity, his wife would not need to give permission for placement.

We were unable to confirm or refute that three facility staff told the patient's wife that she was no longer her husband's POA as the designation had been given to his [her husband's] sister. Patients may designate a healthcare POA, usually a family member or close friend, who can make medical decisions on their behalf in the event that they are ever unable to do so (coma, severe dementia, etc.). In the absence of a formal POA, facility providers look first to the legal spouse, and next to the adult children, to make medical decisions for an incapacitated patient.

The patient did not have a formal POA. His wife was listed as the legal next-of-kin and emergency contact in accordance with the patient's wishes. Therefore, the patient's wife would have been the decision-maker had the patient been unable to make his own medical decisions.

Issue 3. Suicide Prevention Activities

During the course of our review, we found that facility providers did not comply with VHA guidelines for assessing suicide risk; using the high-risk for suicide list and PRF; conducting follow-up at designated frequencies using prescribed methods; and completing a detailed safety plan and reviewing it at regular intervals with the patient.

Assessment and Reassessment of Suicide Risk

Initial Assessment

While the initial SRA was completed at the time of the patient's admission to the facility in late January, we found that the SPC did not consult with the treatment team about the patient's risk level or need for safety planning as required. The DUSHOM memo requires that, "Whenever a veteran is identified as surviving a suicide attempt or is otherwise identified as being at high risk and placed on the high-risk list, the SPC will contact the veteran's primary care and/or mental health provider" to ensure that the care plan includes ongoing monitoring for suicidality and that all suicide safety planning components are completed as required. Further, the SPC functional statement outlines

the SPC's responsibility for "assessing the risk of suicide in individual patients in conjunction with [the] treating clinician..."

On admission to the facility in January, two different clinicians assessed the patient to be at "heightened" risk for suicide. The patient had been admitted for safety concerns related to his recent suicide attempt, as well as for mental health and social issues. The mental health medical student completed the SBR which automatically generated an alert to the SPC. The SPC told us that she reviewed the SBR and the patient's record, but that she had no further role as "mental health had already been consulted."

We found no documented evidence that the SPC reviewed the patient's record, consulted with the clinician or treating team, or otherwise followed this case. In fact, the only document in the patient's medical record that was signed by the SPC was the SBR dated 23 days after the facility became aware of the patient's death.

Reassessment

Clinical staff did not reassess that patient's suicide risk level at the time of his discharge in mid-February. Policy requires that staff communicate the status of high-risk patients when they change levels of care. In this case, the patient was transitioning from an inpatient setting to outpatient care with a new CBOC mental health provider.

While documentation shows that the patient's mood had improved, and he told staff that he would not engage in self-harm as he did not want to hurt his family,[8] many of the patient's medical, psychosocial, and financial issues had not been resolved. Clinicians we interviewed told us they did not think the patient was at risk for suicide after his discharge citing family support and religious faith; however, none of these clinicians documented their thoughts or reasoning in the patient's medical record or completed a new SRA reflecting a "lower" risk.

High-Risk for Suicide List and PRF

Facility staff did not place the patient on the high-risk for suicide list or post a PRF in his medical record as required by policy. In general, these actions would have been completed by the SPC. There were multiple opportunities for staff to post a PRF. Failure to do so contributed to a breakdown of safety net opportunities over the course of the next several months.

The DUSHOM memo requires each facility to "maintain a list of patients at high risk for suicide, including but not limited to, those who have suicidal ideation and those *who survived suicide attempts*…" [emphasis added]. The patient met criteria for placement on the high-risk for suicide list as he was admitted for safety concerns related to his

[8] The patient also said this prior to his January 2011 suicide attempt.

recent suicide attempt and was assessed by two different clinicians at the time of his late January admission as being at "heightened" risk.

VHA Directive 2010-053, Patient Record Flags, dated February 3, 2011, requires that the facility establish a process for requesting, assigning, reviewing, and evaluating PRFs. The facility did not have a policy regarding the management of PRFs but provided us with an internal document outlining "Flag Consideration Criteria," enhanced care requirements for "flagged" patients, and determination of risk levels (lower risk vs. heightened/moderate risk). This document gave an example of language that could be used in a progress note when a patient's risk level changed from "heightened" to "lower."

Despite the patient's serious suicide attempt in January, his "heightened" suicide risk per assessment, and his unchanged medical and psychosocial stressors, staff did not place a PRF or document the reasons that it was not indicated.

Follow-Up of High-Risk Patients

The patient was not routinely evaluated and followed-up by appropriate clinicians after his discharge in mid-February. The DUSHOM memo requires that patients on the high-risk for suicide list be evaluated weekly for the first 30 days after discharge, and at routine intervals up to 90 days, after which a decision is made as to whether the patient requires continued follow-up or can be discontinued from suicide prevention follow-up. Local guidelines state that the SPC will maintain US mail contact with veterans that have survived a suicide attempt and/or are at high-risk for suicide in order to maintain communication through written correspondence and facilitate access to care.

After the patient's discharge, clinical staff contacted him via telephone on February PDD 1, 2, 9, and 14, thereby meeting the contact requirements for the first 2 weeks post discharge. On PDD 17, the CBOC mental health nurse spent about 45 minutes with the patient and documented that he was at "heightened" risk for suicide. After the patient's CBOC visit and suicide risk assessment on PDD 17, there were no further contacts with the patient exploring his current mood, coping, or risk level. In fact, after the patient went to Florida, contact with facility providers was typically initiated by the patient's wife and usually involved requests for medications and bowel and bladder care supplies. The only contact staff had with the patient after PDD 17 was when an SCI/D clinic nurse documented having spoken with him on two consecutive days in mid-April about medication refills.

Although multiple members of the SCI/D treatment team, as well as the CBOC nurse, knew the patient would be temporarily residing in Florida, there was no apparent attempt to continue regular telephone follow-up contacts with him. Alternatively, no one asked Gainesville VAMC staff to follow up with this medically complex patient with a recent suicide attempt who was now in their jurisdiction. Interviewees consistently reported that

they did not think the patient was at risk and that it was not standard practice to make this type of notification in the absence of a clinical or safety concern.

The SPC did not make personal contact with the veteran and establish a US mail contact program with him as required by VHA guidance. Maintaining contact with veterans via mail is known to be an effective suicide prevention strategy.

Suicide Safety Planning

The patient did not complete or receive a formal suicide safety plan as required. The DUSHOM memo requires that all patients who have survived a suicide attempt or are on the high-risk for suicide list complete an individualized suicide safety plan that helps the veteran identify times when he or she is at increased risk and to act to preserve his or her life. It should list situations, stressors, thoughts, feelings, behaviors, and symptoms that suggest periods of increased risk, as well as step-by-step descriptions of coping strategies and help-seeking behaviors that can be used at these times. It must also include directions for the veteran on how to get help 24 hours per day, 7 days per week, local VA phone numbers, and the national suicide prevention hotline number. After reviewing each step with the veteran, a copy of the agreed upon safety plan, clearly identifying the points discussed in each step, should be furnished for the patient and maintained in their record.

While the CBOC nurse documented in a progress note that she completed a suicide safety plan on PDD 17, we were unable to find a copy in the medical record and asked the SPC to assist us in locating the document. The SPC pointed out a section of the SRA and said that the elements included under the risk assessment constituted an acceptable safety plan. However, the risk assessment did not include situations or symptoms suggesting periods of increased risk, nor did it include evidence of a discussion of coping or help-seeking strategies. Further, the SPC was unable to explain how the patient could receive a copy of this "plan" as it was embedded in a larger progress note (which the patient would not receive a copy of).

Upon interview, the CBOC nurse told us that she completed a "verbal" safety plan with the patient that included facility and national hotline contact numbers. The SPC told us that a verbal safety plan was acceptable as the patient was not on the high-risk for suicide list. However, the plan should have been completed in the electronic template and available for review in the patient's medical record, and the patient should have received a copy of the document.

There were no further mental health or patient safety-related contacts with the patient after PDD 17.

Suicide, by its nature, is difficult to predict. During our interviews, treating clinicians generally reported being surprised when learning of the patient's suicide, and bewildered

as to how this physically challenged patient, with limited grasp strength and fine motor skills, was able to complete his suicide in the manner described in the death certificate.

While we cannot say whether implementation of these measures would have changed the outcome in this case, the facility nonetheless did not adhere to VHA guidance on managing this patient at high risk for suicide.

Issue 4. Reporting, Evaluation, and Follow-up

After learning of the suicide event, the former patient safety manager elected to initiate an internal review of the patient's care in order to address whether the lack of a PRF resulted in missed opportunities and if there was continuity of care when the patient returned from Florida.

We found that facility staff did not report the event timely, did not complete an accurate and thorough evaluation of the event, and did not follow-up on identified systems issues.

Reporting

Clinical staff did not complete a SBR or report the patient's death by suicide in a reasonable time, as required. Patient suicide is an adverse event that must be reported to designated QM officials.

In early July, the SCI/D case manager who was coordinating the patient's annual physical examination contacted the wife to discuss Fisher House arrangements. According to the case manager, the wife told her that her husband killed himself in June and then hung up the phone without offering further detail. The case manager told us that she communicated this information to members of the SCI/D treatment team who had been following the patient, but she did not report it to anyone else. She did not complete the SBR, nor did any member of the SCI/D team. The former patient safety manager learned of the event on July 26, more than 2 weeks later.

Quality and Scope of Internal Review

The internal review lacked sufficient consideration of the issues involved. While it did address the two questions posed by the former patient safety manager and commented on the timeliness of the SBR and SRA, it did not address the overall suicide risk management issues that are central to this case.

Concern 1. The review determined that it was "reasonable" that a PRF was not placed on a "chronically depressed, chronically suicidal" patient who was highly involved with treatment team members. The review referenced a SRA completed in August 2010 which stated the patient was at "lower risk." The review author disagreed with the "high"

risk assessed by the private-sector facility in January 2011 (after his suicide attempt), and wrote that, based on a review of the patient's history and severity of the January incident, the high-risk assessment was incorrect and the patient was "low" risk. As such, the PRF would not have been necessary.

The internal review's conclusions were not always supported by the medical record, as follows:

- The August 2010 SRA reflecting lower risk was no longer applicable as the patient's risk factors had changed substantially after it was completed. In addition to the long-standing medical issues and marital discord, we noted these additional risk factors:
  - The patient experienced multiple new or exacerbated chronic stressors including the loss of his home and transportation in a flood, financial concerns, and increasing social isolation as he was living with his son.
  - It was learned via the private-sector hospital documentation that the patient had a brother who committed suicide.
  - The patient actually attempted suicide by cutting his throat. The reviewer alternately described this attempt as serious, and then minimized its severity. A history of a suicide attempt is the strongest predictor of future suicide attempts, as well as death by suicide.
- Two different facility providers completed SRAs on his admission date that found the patient to be at "heightened" risk. The internal review did not document consideration of this data.
- Since the internal review did not find the lack of a PRF to be problematic, no further steps were taken to ensure that staff were initiating PRFs for high-risk patients as outlined in VHA policy.

Concern 2. Multiple facility staff members have collective responsibility for managing suicide risk, but the internal review focused primarily on one provider.

Systems Issues

The internal review identified systems issues including communication between facility and Gainesville VAMC providers, coordination of care when the patient returned to Minneapolis, and limited medical record documentation.

During the course of our review, we identified additional systems issues, as follows:

- There is not a mechanism for the Chief of Mental Health to routinely learn of suicides outside of his Service Line; he told us that he learned of this suicide just prior to our visit.

- The SPC does not monitor whether suicide safety plans are completed using the appropriate template, or if patients receive copies of their plans.
- As discussed above, the SCI/D Clinic nurse did not complete the necessary notifications after learning of the patient's suicide. This lapse could reflect a larger education and training issue.

The SPC told us that a Suicide Behavior Committee (SBC) reviews and discusses all suicide and parasuicide events and identifies systems issues. However, the SBC meeting minutes could not confirm that systems issues were either addressed by the SBC or referred on for second-level action in this case. We found minimal evidence that the systems issues identified in the internal review had been adequately followed up.

Issue 5. Local Policy and Staff Training

During the course of our review, we found that the facility's policy[9] on managing patients with suicidal ideation was deficient. Specifically, we noted that the policy only included a discussion of PRFs in relation to patients discharged from the inpatient mental health unit. Also, the policy did not include any reference to suicide safety planning requirements.

We determined that the SCI/D staff, as well as the members of the mental health consult team that day, completed the mandatory on-line suicide prevention training. This training focused on the clinical aspects of assessing for suicide risk and managing patients at high risk for suicide. It did not appear, however, that SCI/D staff received training on VHA's administrative requirements and processes for managing this population.

Conclusion

We did not substantiate the complainant's allegations that a change in medication contributed to her husband's death by suicide, that managers improperly tried to "commit" him to a Veterans Home, or that staff told her she was not her husband's POA. Medical record documentation reflects that the patient's medication had not been changed. His chronic depression was attributed to his medical and mental health conditions, and to his substantial psychosocial stressors. Further, the medical record does not support the allegations related to the Veterans Home or POA.

However, we found that the SPC did not participate in the evaluation and ongoing monitoring of the patient, and the treatment team did not complete an SRA at the time of the patient's discharge in mid-February, as required. Staff did not place the patient on the

[9] Facility memorandum TX-18B: *Suicide: Screening, Assessment and Management of Patients with Suicide Ideation or Suicide Attempt*, February 1, 2010.

high-risk for suicide list or initiate a PRF, and as a result, the patient did not receive the prescribed level of monitoring and follow-up.

Clinical staff did not complete a SBR or report the patient's death by suicide in a reasonable time, as required. The former patient safety manager learned of the suicide more than 2 weeks after the event.

While an internal review of the patient's death addressed the two questions posed by the former patient safety manager, it did not address the overall suicide risk management issues that are central to this case. Its conclusions were not always supported by the medical record, and it primarily focused on one provider rather than on the team of providers who have collective responsibility for these patients. Further, systems issues identified in the internal review had not been adequately followed up.

Facility policy did not include provisions for PRF placement except for those patients discharged from the inpatient mental health unit, nor did it include any reference to suicide safety planning requirements. Further, SCI/D staff were unaware of some administrative requirements for managing patients at high-risk for suicide.

Recommendations

1. We recommended that the facility Director requires the SPC to take a proactive role in assessing and managing patients at high risk for suicide and/or with recent suicide attempts.

2. We recommended that the facility Director assures patients meeting criteria are placed on the high-risk for suicide list and that a PRF is posted in the medical record, as indicated.

3. We recommended that the facility Director assures that a SRA is completed upon discharge for appropriate patients.

4. We recommended that the facility Director requires clinical staff to comply with enhanced care requirements including follow-up contacts and suicide safety plans.

5. We recommended that the facility Director takes action to address suicide and suicide prevention-related systems issues identified through QM and other processes.

6. We recommended that the facility Director takes action to require the SBC to document discussions and actions in meeting minutes and forward them to appropriate clinical managers for review and oversight.

7. We recommended that the facility Director takes action to update the appropriate suicide prevention and PRF policies in accordance with VHA guidelines.

8. We recommended that the facility Director takes action to assure that facility staff receive training on VHA's administrative requirements and processes for managing patients at high-risk for suicide.

Comments

The Veterans Integrated Service Network and Medical Center Directors agreed with our findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 18-22, for the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Appendix A

VISN 23 Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 15, 2012

From: Director, VA Midwest Health Care System (10N23)

Subject: Healthcare Inspection–Service Delivery and Follow-up After a Patient's Suicide Attempt, Minneapolis VA Health Care System, Minneapolis, MN

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

Thru: Director, VHA Management Review Service (10A4A4)

I have read the Healthcare Inspection report, in addition to the Minneapolis VA Healthcare System response and action plans. I concur with the plan and target dates as set form by the facility.

(original signed by:)

Janet P. Murphy

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: June 15, 2012

From: Acting Director, Minneapolis VA Health Care System (618/00)

Subject: Healthcare Inspection–Service Delivery and Follow-up After a Patient's Suicide Attempt, Minneapolis VA Health Care System, Minneapolis, MN

To: Director, VA Midwest Health Care System (10N23)

I have read the above OIG Healthcare Inspection report and concur with the action plans established. We appreciate the opportunity to address the issues identified and remain committed to providing a high level of care to all our veterans.

(original signed by:)

Barry D. Sharp

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 facility Director requires the SPC to take a proactive role in assessing and managing patients at high-risk for suicide and/or with recent suicide attempts.

Concur Target Completion Date: 8-1-12

Facility's Response: The SPC will review all suicide behavior reports for appropriateness of assignment of CPRS high risk for suicide flag. SPC will provide additional training to areas identified based on the CPRS reviews, and document the additional training in the SBC meeting minutes.

Status: Open

Recommendation 2. We recommended that the facility Director assures patients meeting criteria are placed on the high-risk for suicide list and that a PRF is posted in the medical record, as indicated.

Concur Target Completion Date: 8-1-12

Facility's Response: The SPC will review CPRS information when patients meeting criteria are placed on the high-risk for suicide list. SPC will ensure a PRF is posted in the medical record for patients identified by Suicide Behavior Reports for clinically appropriate assignment of high-risk for suicide flag. PRF reports will be reviewed with Mental Health leadership for monitoring and tracking of any follow up actions.

Status: Open

Recommendation 3. We recommended that the facility Director assures that a SRA is completed upon discharge for appropriate patients.

Concur Target Completion Date: 9-1-12

Facility's Response: Suicide risk assessment element will be added to the Nursing discharge summary note and the MD discharge summary note to

ensure communication of risk of suicide to next level of care. SPC will monitor documentation to ensure compliance and report results to SBC.

Status: Open

Recommendation 4. We recommended that the facility Director requires clinical staff to comply with enhanced care requirements including follow-up contacts and suicide safety plans.

Concur Target Completion Date: 9-1- 12

Facility's Response: SPC will provide education for staff who identify patients at high risk for suicide by Patient record flag, to include required enhanced care elements and SRA. This will be implemented by the outpatient care team and monitored by SPC.

Status Open

Recommendation 5. We recommended that the facility Director takes action to address suicide and suicide prevention-related systems issues identified through QM and other processes.

Concur Target Completion Date: 8-1-12

Facility's Response: The following actions have been implemented to assure that suicide and suicide prevention-related systems issues are addressed through QM and other processes with the following actions: 1) The Patient Safety Manager (PSM) will cosign suicide and parasuicide events reviewed by the Suicide Prevention Coordinator; 2) The SPC will refer any additional quality concerns to the PSM or QMO, who will complete further clinical review if needed and determine if the situation should be referred for peer review or management review as indicated

Status: Open

Recommendation 6. We recommended that the facility Director takes action to require the Suicide Behavior Committee to document discussions and actions in meeting minutes and forward to appropriate clinical managers for review and oversight.

Concur Target Completion Date: 8-1-12

Facility's Response: SPC will ensure discussions and actions are documented in SBC meeting minutes to reflect any outcomes and/or actions

related to the reviewed information. All actions identified in meeting minutes will be forwarded to appropriate clinical managers for review, oversight and closure.

Status Open

Recommendation 7. We recommended that the facility Director takes action to update the appropriate suicide prevention and PRF policies in accordance with VHA guidance.

Concur Target Completion Date: 10-31-12

Facility's Response: The facility policy will be reviewed and updated to ensure compliance with VHA guidelines. SBC Charter will be reviewed and updated to ensure proper reportability under governance structure to align under Quality Management Council which also includes an oversight function of Patient Safety.

Status: Open

Recommendation 8. We recommended that the facility Director takes action to assure that facility staff receive training on VHA's administrative requirements and processes for managing patients at high risk for suicide.

Concur Target Completion Date: 9-1-12

Facility's Response: SPC will work with the education department to review and revise current training module to include elements of the facility policy and VHA guidelines for managing patients at high risk for suicide.

Status Open

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, MBA Monika Gottlieb, MD Susan Zarter, RN

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