Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Emergency Department Evaluation of a Homeless Veteran
VA North Texas Health Care System
Dallas, Texas

Report No. 12-04214-83 **January 7, 2013**

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 an inspection to determine the validity of an allegation related to a patient being denied inpatient mental health treatment at the VA North Texas Health Care System (facility) in Dallas, TX. Specifically, the complainant alleged that a patient presented to the Emergency Department (ED) with suicidal ideation and had to wait in the triage holding area for over 4.5 hours prior to being seen by a psychiatrist. The psychiatrist told the patient that admission was not indicated. The patient had a panic attack, and the police were called to escort the patient out of the facility as the patient was upsetting the staff.

We did not substantiate that a suicidal patient was denied admission for inpatient treatment. We interviewed staff, reviewed the patient's electronic health record, and reviewed facility policies. Although the patient's electronic health record documented the patient was hopeless and depressed, it also documented that the patient denied suicidal ideation.

We determined that there was no facility policy or standard operating procedure written to describe the process for patient evaluations in the ED; therefore, there was no training on such a policy or procedure for anyone working in the ED. This may have contributed to the long ED visit for the patient and influenced the patient's decision to leave against medical advice.

We also reviewed the patient's ED Integration Software (EDIS) tracking sheet that is used to monitor a patient's real-time movement through the ED. The tracking sheet did not match the patient's electronic health record. ED administrative and clinical staff do not consistently update EDIS as required.

In addition, social workers on call for the ED after hours did not assist homeless patients to find a shelter or direct them to the Healthcare for Homeless Veterans program as required.

We recommended that the Facility Director ensure that the facility develops a written policy for ED patient evaluation and provide orientation to all ED staff and on-call personnel; EDIS is used as required; and social work services are provided in the ED as required.

The Veterans Integrated Service Network and Facility 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 Heart of Texas Health Care Network (10N17)

SUBJECT: Healthcare Inspection – Emergency Department Evaluation of a Homeless Veteran, VA North Texas Health Care System, Dallas, Texas

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection to determine the validity of an allegation regarding denial of inpatient treatment of a suicidal patient by an Emergency Department (ED) provider at the VA North Texas Health Care System (facility) in Dallas, TX.

Background

The facility is part of Veterans Integrated Service Network 17 and provides a broad range of inpatient and outpatient healthcare services to nearly 500,000 veterans in 40 counties in north Texas and southern Oklahoma. The facility has 613 hospital beds and 240 Community Living Center beds.

ED Requirements

Veterans Health Administration (VHA) requires that an ED is staffed and equipped to provide initial evaluation, treatment, and disposition for a broad spectrum of illnesses, injuries, and psychiatric disorders regardless of the level of severity and operates 24 hours a day, 7 days a week (24/7).[1] VHA requires EDs to have Mental Health (MH) coverage by an independent licensed MH provider during all hours of operation, either on call or on site.

ED Support Services

The MH Service at the facility has five positions designated for the ED. Earlier this year,

[1] VHA Directive 2010-010, *Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities*, March 2, 2010.

three of the providers resigned. In order to continue to provide 24/7 MH coverage in the ED, MH providers who worked in other areas of the facility volunteered to work the open shifts created by the vacancies. Prior to providing ED coverage, the psychiatrists reviewed a Psychiatry Service Emergency Room Orientation Packet. The orientation packet did not include a review of standard operating procedures (SOPs) for patient evaluations in the ED.

VHA requires each ED to have 24/7 social work (SW) services to assist in facilitating veterans access to veterans' benefits and referral to any non-clinical services needed by the veteran.[2] Further, VHA requires ED staff to be aware of the facility's available services to assist homeless veterans through the assigned Healthcare for Homeless Veterans (HCHV) outreach workers. These workers link homeless veterans to appropriate treatment and social services and refer the veteran (and family) to these staff members for assistance. At the facility, social workers assigned to the HCHV program are under MH Service, not SW Service. Only social workers in SW Service are on call to the ED after hours.

VHA requires that police are available when requested to provide standby assistance or intervention for the management of any patient who presents a danger to self or others, is potentially violent, or exhibits violent or agitated, unpredictable behavior.[3]

ED Integration Software (EDIS)

In 2008, VHA implemented the use of EDIS to provide a viewable digital log of critical activities in the ED. It produces a centrally located display of all active patients in the ED as well as their location, status, and providers. It incorporates several web-based views that help staff track and manage patient flow and patient care.[4] VHA requires facility ED Directors to ensure the use of EDIS by all administrative and clinical staff in the department.[5]

Allegation

In August 2012, a complainant contacted the OIG's Hotline Division alleging a patient presented to the ED with suicidal ideation (SI) and had to wait in the triage holding area for over 4.5 hours prior to seeing a psychiatrist. The psychiatrist told the patient admission was not indicated. The patient had a panic attack, and the police were called to escort the patient out of the facility because the patient was upsetting the staff.

[2] VHA Directive 2010-010.
[3] VHA 2010-008, *Standards for Mental Health Coverage in Emergency Departments and Urgent Care Clinics in VHA Facilities*, February 22, 2010.
[4] VHA, *Introductory Training to EDIS*, October 2008.
[5] VHA Directive 2011-029, *Emergency Department Integration Software (EDIS) for Tracking Patient Activity in VHA Emergency Departments and Urgent Care Clinics*, July 15, 2011.

Scope and Methodology

We interviewed the subject of the allegation by telephone on September 11, 2012. We conducted interviews at the facility with clinicians and other employees with knowledge of the issues raised by the allegation on September 27 and 28, 2012. We reviewed policies, procedures, and the patient's electronic health record (EHR). Additionally, we reviewed the EDIS patient-tracking sheets for the day involved in the allegation.

We conducted the inspection 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 in his twenties with a history of panic disorder, depression, posttraumatic stress disorder (PTSD), and drug abuse. Facility MH providers have been treating him since April 2012.

In July 2012, a MH provider at the Fort Worth Outpatient Clinic (FWOPC) saw the patient during a scheduled appointment with complaints of increased anxiety and panic attacks. The provider's note documented that the patient was upset and tearful due to financial issues and homelessness. The provider asked the patient if he felt like he needed hospital admission because of the increased anxiety, but the patient felt outpatient services would be enough. The patient denied SI. The provider adjusted the patient's psychiatric medications and provided him with information on how to get help after hours if needed and scheduled a follow-up appointment in 2 weeks.

The next evening, at approximately 5:30 p.m., the patient presented to the ED. The triage Registered Nurse (RN) note states that the patient was complaining of increased anxiety, PTSD, and feeling depressed; however, he denied SI. The note documented that the patient was crying during the evaluation, the provider at FWOPC said admission was possible, and that the patient was recently homeless. The patient reported that the triage RN had him wait in the holding area of the ED.

At approximately 7:30 p.m., the on-call psychiatrist for the ED began evaluating the patient. The psychiatrist's note documented that the patient wanted to be hospitalized for increased anxiety and panic attacks related to finances and homelessness, but the provider did not feel admission was warranted. The patient did not think his current medications (including a new medication started the day before for panic attacks) were effective; the new medication made the patient drowsy. The psychiatrist documented that the patient denied depression and SI; however, the patient felt helpless, frustrated, angry, and was worried about the future. The patient had not abused non-prescription drugs for the last 3 weeks but was having cravings that evening. The assessment documented that the

patient was alert and oriented, cooperative, without any psychomotor abnormality, and goal-directed. The note documented that the psychiatrist spent 30 minutes with the patient.

Through evaluation of the patient, the psychiatrist determined his condition did not warrant inpatient treatment for stabilization. The psychiatrist's plan included the patient keeping his scheduled follow-up appointment with the FWOPC MH provider and contacting a social worker to arrange shelter for the patient.

During our interview with the patient, he reported having a panic attack when he was told that he would not be admitted. He stated that the police were called, threatened to arrest him, and walked him out of the building. He reported that he said, "I might as well go out and kill myself if you are not planning on doing anything for me."

The EHR documented that while the psychiatrist was in the process of contacting a social worker, the patient left at 10:50 p.m., against medical advice.

Three days later, the patient presented to the FWOPC complaining of anxiety, panic attacks, and depression about finances and homelessness. The provider noted that the patient was feeling hopeless, helpless, and felt he needed hospitalization for stabilization of anxiety and now reported SI. The patient denied having a plan for self-harm but stated, "I just don't care what happens anymore…" The EHR documented that the patient relapsed with drug abuse, reportedly to stay calm after leaving the ED. The FWOPC provider arranged for the patient to be admitted to the facility.

The patient was hospitalized for 8 days and discharged with MH follow-up care at the FWOPC. He was able to obtain housing in Fort Worth through the Grant Per Diem[6] program.

Inspection Results

Issue 1: Improper Treatment of a Suicidal Patient

We did not substantiate that a suicidal patient was treated improperly.

Although it was alleged that the patient complained of SI, our review did not support that allegation. All EHR notes reviewed documented that the patient denied SI but had feelings of hopelessness and depression.

Although it was alleged that police were called when the patient was having a panic attack and the patient said he told the police officers he would kill himself, we did not find a police report of this incident. During our interviews, the police officers said that if they are called for an agitated patient, they attempt to calm the patient and would not

[6] Grant Per Diem is a VHA transitional housing program.

write a report if the patient cooperated. However, all officers emphatically stated that they would never allow anyone to leave who said anything about suicide. In these cases, they would document the incident in a report and detain the individual in the ED until medically cleared.

Issue 2: No Written SOP for ED Patient Evaluation

We found that there is no written SOP for patient evaluation in the ED.

During our interviews, staff reported that all patients are assigned an ED provider after being evaluated by the triage RN. The ED provider is the patient's primary provider in the ED. If a patient presents with MH concerns, the triage RN is to contact the MH provider on-call for the ED in addition to assigning an ED provider. Either the ED provider or the MH provider may evaluate the patient first, but both are to see the patient and the MH provider is to discuss findings with the ED provider. If admission to the MH inpatient unit is deemed necessary, the MH provider is responsible for admission. If the patient is to be discharged home from the ED, the ED provider must see and discharge the patient. However, there is no written SOP or facility policy describing this process for patient evaluation in the ED.

Issue 3: Improper Use of EDIS

During our review, we found that the facility's ED is using EDIS; however, it is not being used according to VHA guidelines.

We reviewed the patient-tracking sheet from EDIS for the subject patient. The patient-tracking sheet did not match the patient's EHR. The on-call psychiatrist saw the patient, but EDIS had no record of the patient being seen. According to the EDIS report, the patient never left the waiting room. The patient EHR documented that the patient left against medical advice at 10:50 p.m.; however, EDIS showed that at 11:54 p.m. the patient was discharged home.

During our interviews, we found that EDIS is not consistently updated in real time by the ED staff as required.

Issue 4: SW services

During our interviews, we reviewed the process of how SW services are provided to homeless veterans presenting to the ED after hours. SW services are provided by on-call social workers from SW Service and not by social workers from MH Service, including those in the HCHV program.

During our interviews, we found that the HCHV program has provided the ED with a list of shelters in the Dallas-Fort Worth area that can be offered to patients who wish to go to a shelter to see if a bed is available after hours. On-call SW Service social workers have

the RN or provider tell the patient to return in the morning or have the patient stay in the ED waiting room (offering the patient a blanket and a food tray) until morning. They did not report assisting patients in finding a shelter or referring patients to the HCHV program from the ED as required by VHA.

Conclusions

We did not substantiate that a suicidal patient was treated improperly in the ED. We did find that various process issues contributed to the patient's experiences in the ED. First, the psychiatrist involved in the patient's care was a MH provider who was working extra shifts in the ED to support continued 24/7 MH services. The absence of ED orientation for these staff members may have contributed to the patient's long wait time, not receiving the services required, and leaving against medical advice. The lack of real-time EDIS tracking likely contributed to the ED's failure to recognize the patient's true wait time and may not provide the facility with accurate information for process improvement. Finally, on-call social workers for the ED do not follow guidelines for providing assistance in helping homeless veterans find a shelter or directing them to the HCHV program the following morning.

Recommendations

Recommendation 1. We recommended that the Facility Director ensure that the facility develops a written SOP for emergency department patient flow and orientation is provided to all emergency department staff and on-call personnel.

Recommendation 2. We recommended that the Facility Director ensure that EDIS is used as required.

Recommendation 3. We recommended that the Facility Director ensure that SW services are provided in the emergency department as required.

Comments

The VISN and Facility Directors concurred with our findings and recommendations and provided acceptable improvement plans. (See Appendixes A and B, pages 7–10, for the full text of 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

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 18, 2012

From: Director, VA Heart of Texas Health Care Network (10N17)

Subject: **Healthcare Inspection – Emergency Department Evaluation of a Homeless Veteran, VANTHCS, Dallas, Texas**

To: Director, Dallas Office of Healthcare Inspections (54DA)

Thru: Director, VHA Management Review Service (VHA 10AR MRS OIG Hotlines)

1. Thank you for allowing me to respond to this Healthcare Inspection at the VA North Texas Health Care System, Dallas, TX.

2. I concur with the recommendations and have ensured that action plans with target dates for completion were developed.

3. If you have further questions regarding this inspection, please contact Denise B. Elliott, VISN 17 Health Systems Specialist at 817-385-3734.

Lawrence A. Biro
Director, VA Heart of Texas Health Care Network (10N17)

Appendix B

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date: December 14, 2012

From: Director, VA North Texas Health Care System (549/00)

Subject: **Healthcare Inspection – Emergency Department Evaluation of a Homeless Veteran, VANTHCS, Dallas, Texas**

To: Director, VA Heart of Texas Health Care Network (10N17)

1. We appreciate the opportunity to review the draft report of the inspection completed September 27–28, 2012, at the VA North Texas Health Care System in Dallas, TX.

2. Attached you will find the implementation plan for each finding.

3. If you have any questions, please call Tracye Davis, Executive Assistant to the Director, 214-857-1175.

(original signed by:)

Mr. Jeffery Milligan
Director, VA North Texas Health Care System (549/00)

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 ensure that the facility develops a written SOP for ED patient flow and orientation is provided to all ED staff and on-call personnel.

Concur **Target Completion Date:** March 30, 2013

Facility's Response:

The written Standard Operating Plan will be completed and the orientation for Emergency Department (ED) patient flow will be provided to all ED, Mental Health (MH) and on-call personnel by March 30, 2013.

Status: In progress

Recommendation 2. We recommended that the Facility Director ensure that EDIS is used as required.

Concur **Target Completion Date:** March 30, 2013

Facility's Response:

The consistent and accurate use of EDIS for time-stamping events has been hampered by two issues:

a. Lack of a user-friendly interface for efficient interaction with EDIS.

b. The program timing-out after a very short period of time if minimized or in the background on the computer desktop, requiring repeated log-in.

Issue (a) will be improved with the next generation of EDIS which was scheduled for deployment last month, but has been delayed for an unknown time.

Regarding issue (b), the local ISO has been contacted to request permission to authorize IT to allow for a longer time-out on EDIS. This has been done at other VA hospitals.

Status: In progress

Recommendation 3. We recommended that the Facility Director ensure that SW services are provided in the ED as required.

Concur **Target Completion Date:** April 30, 2013

Facility's Response:

Social Work Service (SWS) will ensure an on-call Social Worker has direct communication with the Veteran, rather than speaking only to the ED physician or nurse. (Implemented December 13, 2012.) All SWS staff will be re-educated in regards to the HCHV programs during the next staff meeting (January 2013). Information and emergency shelter list was added to the on-call notebook, for reference (implemented December 13, 2012). SWS will collaborate with HCHV to develop a warm hand-off process for after-hours homeless Veteran's needs. SWS will audit documentation of after-hours ED contact to ensure appropriate follow up. These audits will include 100 percent of ED contacts each month, for at least 90 percent compliance for 3 consecutive months.

Status: In progress

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	Cathleen King, MHA, CRRN, Project Leader Gayle Karamanos, MS, PA-C, Team Leader Rose Griggs, MSW, LCSW Robert Yang, MD, Medical Consultant Misti Kincaid, BS, Management and Program Analyst

Appendix D

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