Administrative Closure
Alleged Denial of Treatment
of an Actively Suicidal Veteran
Tennessee Valley Healthcare System – Nashville (626/00)
Nashville, TN
MCI# 2013-03411-HI-0477

The VA Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) received a complaint from (b)(3):5 U.S.C. App 3 (IG Act):(b)(6) (complainant), alleging that (b)(3):5 U.S.C. App 3 (IG Act):(b)(6) (b)(3):38 U.S.C. 5701.(b)(6) (patient), was denied care at the Emergency Department (ED) of the Tennessee Valley Healthcare System, Nashville Campus (facility), Nashville, TN, after reporting that he was having suicidal thoughts. The complainant alleged that the facility failed to triage, stabilize, or arrange transfer to a community hospital.

OHI's Hotline triage group sent the allegation to the facility in June for review. Facility managers sent a response to OIG's Hotline Division (53E) stating that the patient was ineligible for care and had no electronic health record within their system. From their review, they did not find any record of the patient presenting to the facility and planned no further action. The OHI triage group considered the facility's response and, on August 15, opened a formal review.

We visited the facility on September 23–25, 2013, conducted interviews with facility leadership, key employees, and toured the ED. We interviewed the complainant, patient, and VA's Veterans Crisis Line staff. We reviewed VHA and facility policies, memoranda, and procedures, facility telephone records, the patient's (b)(6) health records, and cellular telephone records. We reviewed facility ED quality indicators, staffing and staff training records, incident reports, and other documents for the period of July 2012–June 2013.

The complainant is a veteran who receives care at the facility and (b)(6) (b)(6) The patient and complainant said that they were aware of his ineligibility for facility care. However, because his suicidal thoughts were related to the recent death of former veteran comrades, the patient called the facility's crisis line for support on (b)(6). According to the patient, a facility crisis line social worker told him to go to the facility ED. When the complainant and patient arrived at the facility between 5:00 p.m. and 7:00 p.m., the ED waiting room was empty. The ED administrator on duty (AOD) took the patient's identifying information, and asked the couple to take a seat in the waiting area. The patient (b)(3):38 U.S.C. 7332.(b)(6) (b)(3):38 U.S.C. 7332.(b)(6) and that he was having suicidal thoughts. The AOD informed the couple that the patient was ineligible for care at the facility and told them to go to one of three community hospitals. The complainant asked to speak with the "administrator or house supervisor" to which the AOD replied, "That's me." The couple left and went to (b)(6) where the patient was admitted.

(b)(6) medical records indicated that the patient presented to the (b)(6) at approximately 8:00 p.m. on (b)(6) (b)(3):38 U.S.C. 7332.(b)(6) and expressing suicidal ideation with a plan to shoot himself. He was admitted to (b)(6) 's inpatient mental health unit with a diagnosis of (b)(3):38 U.S.C. 7332.(b)(6) and suicidal ideation. The (b)(6) record did not include any reference to the patient presenting to the facility prior to accessing care at (b)(6). He was discharged from (b)(6) 5 days later with a continuing care treatment plan.

The facility has a policy for humanitarian care and a code of ethics which states that any "...Veteran requiring emergency hospitalization will be admitted regardless of eligibility" and that a veteran will "...be treated to stabilize his/her condition..." prior to transfer. The code of ethics

also states that, "Ineligible Veteran patients who require non-emergency hospitalization will be transferred to a non-VA hospital for that care as soon as possible." Facility leaders and ED staff were able to appropriately describe these policies and reported that redirection to another hospital or care is provided routinely to non-veterans.

The complainant and patient appeared very credible in their consistent report and description of events. However, we were unable to confirm the patient's visit to the facility on (b)(6). An absence of staff recollection and other information, such as AOD, surveillance, ED, crisis line phone, and electronic health records prevent us from independently evaluating whether or not the facility denied treatment to this veteran. Therefore, we cannot substantiate the allegation.

In the course of our review, we made several observations related to the facility ED. We communicated these observations to the facility and VISN 10 leadership on Jan 22, 2014, including the facility's lack of:

- Adequate research prior to responding to OHI's hotline triage group
- Clinical versus administrative gatekeeping for ED entrants
- AOD training on suicide prevention
- Clear ED signage (potentially contributing to frequently mistaken access by non-veterans seeking the (b)(6)
- Record keeping and quality analysis of crisis line and ED activities
- Outreach or service recovery to the complainant and patient

Based on our review, this hotline inspection is administratively closed.

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1/31/14