Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 14-02139-156

Healthcare Inspection

Suicide Risk and Alleged Medical Management Issues Hampton VA Medical Center Hampton, Virginia

March 30, 2015

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection at the request of Senator Richard Burr, the then Ranking Member of the Senate Committee of Veterans' Affairs, to assess the merit of allegations received from a complainant concerning the clinical management of a veteran who reported a suicide attempt and failure to diagnose a cardiac condition at the Hampton VA Medical Center (facility), Hampton, VA.

The veteran died several weeks after the reported suicide attempt. The medical examiner who performed an autopsy stated that "The manner of death is accident" and recorded the cause of death as the combined toxic effects of two medications, a narcotic pain reliever and an anti-anxiety medication, with severe disease of one coronary artery (a blood vessel that supplies the heart muscle) contributing to the death.

We substantiated that the veteran's reported attempt to commit suicide was not managed as required by Veterans Health Administration (VHA) policy. We found that although all but one of the clinical staff members in the facility's Emergency Department and Mental Health clinics had completed suicide risk management training, they did not identify the veteran's suicide risk factors and did not report his recent suicidal behavior as required by VHA.

We substantiated the allegation that the veteran suffered from undiagnosed heart disease. However, his complaints of chest pain and shortness of breath had been evaluated on several occasions. We found that his physical exam, laboratory studies, and four electrocardiograms were within normal limits and did not support a need for a further, more invasive evaluation.

We found that contracted providers were not required to undergo suicide risk management training.

We recommended that the Facility Director ensure that contracted providers in all patient care locations complete VHA's suicide risk management training and develop a process to measure effectiveness of the training for all staff who have completed it and provide remedial training when needed.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 9–11 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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Senator Richard Burr, the then Ranking Member of the Senate Committee of Veterans' Affairs, to assess the merit of allegations concerning the clinical management of a veteran who reported a recent suicide attempt and failure to diagnose a cardiac condition at the Hampton VA Medical Center (facility) in Hampton, VA.

Background

A. Hampton VA Medical Center

The facility provides comprehensive health care through primary, acute inpatient, psychiatric, chronic spinal cord injury, long term domiciliary rehabilitative residential care, hospice, and palliative care. Primary and mental health (MH) services are also provided at community based outpatient clinics (CBOCs) in Virginia Beach, VA, and Elizabeth City, NC. The facility has a veteran population of more than 240,000 throughout a 15 county region in eastern Virginia and northeastern North Carolina and is part of Veterans Integrated Service Network (VISN) 6.

B. Allegations

In February 2014, OIG received the following allegations:

- A veteran reported a suicide attempt and did not receive follow-up as required, which could have prevented his subsequent death by drug overdose.
- An occlusion in one of the veteran's coronary arteries, found during autopsy, was not diagnosed or treated by the facility. No electrocardiogram (EKG) was performed during his treatment.

C. Clinical Overview

VHA Suicide Risk Management Program History

In 2007, responding to published findings that male veterans were at approximately twice the risk for suicide as compared to male non-veterans,[1] Congress passed the Joshua Omvig Veterans Suicide Prevention Act, which directed VA to create a comprehensive suicide prevention program to address suicide among the veteran population.

[1] Kaplan M.S, Huguet N, McFarland H, Newsom JT. *Suicide among male veterans: prospective population–based study*. Journal of Epidemiology and Community Health, Jul 2007; 61(7): 619–624.

Suicide Risk Management Training

The Veterans Health Administration (VHA) developed a web-based learning program to educate health care providers on suicide risks as well as interventions or strategies for suicide prevention. VHA required all health care providers to successfully complete the training no later than December 30, 2008, or within 90 days of entering a position for those subsequently hired. For purposes of this training requirement, VHA defined a provider as a "…full-time, part-time, or intermittent employee engaged in patient care as a Physician, Psychologist, Registered Nurse, Social Worker, Physician Assistant, Pharmacist, or Dentist." Trainees were exempt from the training requirement.[2]

The mandatory training included the following information about patient history and behavior that should alert providers to the need to assess suicide risk.

- "In most cases, suicidal ideation [thinking about suicide] is believed to precede the onset of suicidal planning and action."

- "Many individuals will initially deny the presence of suicidal ideation for a variety of reasons…"

- "Even if denied, certain observable cues… should prompt the clinician to remain alert to the possible presence of suicidal ideation [and] include profound social withdrawal, irrational thinking, paranoia, global insomnia, depressed affect, agitation, anxiety, irritability, despair, shame, humiliation, disgrace, anger and rage."

Psychosocial factors are also associated with suicide risk, including loss of employment or relationship difficulties. The training emphasized that a history of a suicide attempt is the strongest predictor of future suicide attempts, as well as death by suicide.

VHA Suicide Risk Assessment and Reporting

VHA developed a program of suicide risk assessment and suicide prevention that included standardized screening questions followed by in-depth evaluation with assessment of suicide risk when screenings were positive. VHA established the High Risk for Suicide Patient Record Flag (PRF) to alert providers about patients at high risk for suicide.[3] The need for the PRF is determined by an in-depth assessment based on VHA's defined criteria; if the assessment indicates high risk for suicide, then placement of the PRF is required. A PRF is presented to providers immediately upon accessing the electronic health record (EHR).

VHA requires use of "carefully defined criteria to ensure that the PRF is appropriately used and maintains its clinical safety value. This determination needs to be made cautiously, and a record flagged only in the event that additional care should be taken by everyone interacting with the patient to attend to the increased risk for suicide.

[2] VHA Directive 2008-051, *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, August 28, 2008.
[3] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.

Reporting of suicidal thoughts or a call to the national suicide hotline alone is not an automatic indication of high risk."[4]

VHA requires each VA medical center to appoint a Suicide Prevention Coordinator (SPC).[5] The SPC's duties include responding to reports about suicide attempts and working with providers to ensure intensified monitoring and treatment for high risk patients. VHA implemented Suicide Behavior Reports (SBR) for notifying SPCs about high risk patients and for SPC reporting to VHA's national suicide prevention database, and instructed that, "When providers become aware of actual attempts, they should complete a Suicide Behavior Report…"[6,7]

Scope and Methodology

The veteran's suicide attempt and subsequent death occurred more than 3 years ago; accordingly, we evaluated the care provided at the facility and CBOC for compliance with standards in effect at that time. We conducted a site visit August 26, 2014. We interviewed the complainant, senior managers, and clinical and administrative staff with current or historic knowledge of suicide risk management processes. Although a few key staff, including the veteran's primary CBOC MH provider, were no longer employed by the facility, we attempted to obtain contact information and interviewed those individuals who were available.

We reviewed relevant facility and VHA policies and procedures that were effective at the time that care was rendered, staff training records, and the veteran's EHR and non-VA records, including the medical examiner's autopsy report and the veteran's death certificate.

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.

[4] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide,* July 18, 2008.
[5] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics.* September 11, 2008.
[6] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide,* July 18, 2008.
[7] Deputy Under Secretary for Health for Operations and Management Memorandum, *Patients at High Risk for Suicide,* April 24, 2008.

Case Summary

The veteran was a young adult with a history of depression and sleep disorder (insomnia) who had received MH services at a facility CBOC for approximately 4 years. In addition to individual counseling, he received medication to manage his psychiatric symptoms.

He was treated with various medications that were adjusted or changed several times during the course of his treatment in response to his reports of ineffectiveness or side effects. He reported insomnia accompanied by excessive daytime sleepiness and received medication for these problems. At the time of his death, he was prescribed three medications used to improve mood symptoms and treat insomnia.

Approximately 2 months before he died, the veteran entered the facility's Emergency Department (ED) late in the evening seeking treatment for insomnia. He reported to the triage nurse that he had attempted suicide 2 nights prior because his insomnia was so severe. The patient denied current suicidal ideation (despite his report of a recent suicide attempt). The triage nurse recorded his vital signs and assigned an appropriate triage level.

The ED provider saw the veteran approximately 20 minutes later and noted that he "couldn't sleep and briefly thought about taking additional medications that could hurt him but didn't." Although the provider's note did not document a recent suicide attempt, it included denial of current suicidal ideation. The provider diagnosed insomnia and anxiety, prescribed sleep medication and a small supply of tranquilizers for treatment, and advised the veteran to follow up with his primary provider in 2–3 days or return to the ED if he had thoughts of suicide.

Two days later, rather than following up with his CBOC primary MH provider, the veteran visited the facility MH clinic where he reported his suicide attempt to a psychiatric nurse clinician and then to a resident physician. The physician noted that the veteran's attempted suicide occurred while he was at work and that he had injected intravenous medications—fentanyl (pain medication), midazolam (anti-anxiety medication), and propofol (an anesthetic). The veteran also reported that the night of the attempt, he was discovered, assessed at a community hospital, and sent home. At this facility clinic visit, he requested help for his medical issues including insomnia and depression.

Both the nurse clinician and the physician documented the recent suicide attempt and denial of current suicidal ideation. The physician offered inpatient treatment, which the veteran declined. She decided that the veteran could not be admitted involuntarily to an inpatient unit. She made changes to the veteran's medication regimen, addressing the problems of insomnia, depression, and anxiety; advised the veteran to follow up with his regular MH provider at the CBOC as soon as possible; and arranged an appointment for screening for admission to the facility's domiciliary program.

The veteran missed his screening appointment for admission to the domiciliary program. He visited the facility's MH clinic the day after this missed appointment, was evaluated by a nurse, and was rescheduled for the screening.

Ten days later, he saw his CBOC MH provider who noted his job loss following illicit activity at work and counseled him against using injectable medications for sleep. The provider documented denial of current suicidal ideation but did not refer to the recent suicide attempt. The provider adjusted the veteran's medications and advised him to return in 1 month or earlier if needed.

Approximately 6 weeks after his CBOC MH clinic visit, the veteran was discovered dead at home. The medical examiner recorded the cause of death as combined fentanyl and midazolam toxicity with severe disease of one coronary artery (a blood vessel that supplies the heart muscle) contributing to his death. The examiner's report further stated, "The manner of death is accident."

Inspection Results

Issue 1: Management of Suicide Risk

We substantiated that the veteran's report of an attempt to commit suicide was not managed as required by VHA policy. VHA's list of indicators of high risk for suicide included a current verified report of attempted suicide.[8] The veteran reported his recent suicide attempt to the triage nurse and several other clinicians at the facility during his ED and MH clinic visits there.

Although the triage nurse noted the veteran's report of a suicide attempt, the ED provider's progress note did not specifically refer to a suicide attempt. Following examination and treatment of the veteran, the provider released him from the ED without further suicide risk management but with limited medication supplies and instructions to return to the ED immediately if he experienced suicidal ideation and to his primary provider in 2–3 days if the prescribed treatment was not effective.

Upon the veteran's return to the facility 2 days later, the MH clinic nurse also documented his suicide attempt. The veteran was further evaluated by a resident physician. As a trainee, the resident physician was exempt from the suicide risk management training requirement; although, the supervising physician who discussed the case with the resident had completed the training.

Clinical staff we interviewed described the veteran as not at risk for suicide because he lacked current suicidal ideation. However, the veteran had reported a recent suicide attempt and other signs and symptoms (insomnia and anxiety) that, according to VHA training, should alert clinicians to the need for further suicide risk assessment. Notwithstanding the denial of suicidal thoughts, the veteran's reported suicide attempt required his clinicians to report his recent suicide attempt to the SPC.

[8] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide,* July 18, 2008.

Specifically, VHA requires clinical staff members to complete the SBR when they become aware of a suicide attempt.[9,10] The facility had a SBR progress note template that included instruction for designating the SPC as an additional signer of the note, to facilitate notification and receipt of the SBR. Once the SPC became aware of a completed SBR, VHA required the SPC to take certain actions, including:

- Assessing the risk of suicide in individual patients, in conjunction with treating clinicians.[11]
- Ensuring that veterans identified as surviving a suicide attempt are evaluated at least weekly for the following month at a minimum.[12]
- Tracking and reporting on veterans determined to be at high risk for suicide and veterans who attempt suicide.[13]
- Ensuring that veterans identified at high risk for suicide receive follow-up for any missed mental health and substance abuse appointments and that this follow-up is documented in the EHR.[14]
- Ensuring a Category II PRF is used as an alert for veterans at high risk for suicide.[15]

Neither the ED nor the facility MH staff who were aware of the veteran's reported suicide attempt completed an SBR. Although the information about the patient's suicide attempt was in the record, the CBOC MH provider did not document awareness of a recent suicide attempt and also did not complete an SBR. Because the SPC was not notified of the recent suicide attempt, she did not initiate the required actions for suicide risk management.

With the exception of one provider, who was an intermittent employee working on a contractual basis, the clinicians who interacted with the veteran had successfully completed the required suicide risk management training. The facility required its contracted providers to complete certain other VHA training modules but not suicide risk management training. Even among staff who had completed the required suicide risk management training, one individual stated being unaware of the SPC's role in the facility.

[9] Deputy Under Secretary for Health for Operations and Management memorandum, *Patients at High-Risk for Suicide*, April 2, 2008.
[10] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.
[11] *ibid.*
[12] *ibid.*
[13] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics.* September 11, 2008.
[14] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.
[15] *ibid.*

Issue 2: Undiagnosed Heart Disease

We substantiated the allegation that the veteran suffered from undiagnosed cardiac disease. The medical examiner's report indicated evidence of single vessel atherosclerosis with 80 percent occlusion of the proximal left anterior descending artery. Despite the significant occlusion, the myocardial tissue showed no evidence suggesting the veteran had ever suffered a myocardial infarction (heart attack).

Our review of the EHR revealed documented complaints by the veteran of chest pain and shortness of breath, but physical exam, laboratory studies, and four EKGs were within normal limits and did not support a need for a further, more invasive evaluation. The veteran was known to have several risk factors for heart disease including hypertriglyceridemia (elevation of certain fats in the blood) and obesity. To address his risk factors, appropriate referrals to the Nutrition Service, as well as exercise and dietary education, were routinely offered.

Conclusions

We substantiated the allegation that the veteran did not receive follow-up for his reported suicide attempt as required by VHA policy.

We found that despite completing the required suicide risk management training, clinical staff members in the ED and MH clinics did not initiate SBRs designed to alert the SPC to a patient's high risk for suicide. Clinicians documented his reported suicide attempt in progress notes; however, because the veteran lacked current suicidal ideation, they did not perceive him to be at risk and thus did not report his recent suicidal behavior to the SPC for management as VHA required.

The facility did not require contracted providers to complete the suicide risk management training. Contracted providers may treat patients in various health care settings, including the facility's ED. The ED is a setting where patients may seek treatment outside regular clinic hours, for psychosocial as well as physical complaints, and the ED may be the first or only setting in which a patient has contact with a provider.

We substantiated the allegation that the veteran suffered from undiagnosed cardiac disease. Our review of the EHR revealed documented complaints by the veteran of chest pain and shortness of breath, but physical exam, laboratory studies, and four EKGs were within normal limits and did not support the need for a further, more invasive evaluation. His identified risk factors were addressed by referrals to the Nutrition Service, and exercise and dietary education were routinely offered to the veteran.

We made two recommendations.

Recommendations

1. We recommended that the Facility Director ensure that contracted providers in all patient care areas complete the Veterans Health Administration's suicide risk management training.

2. We recommended that the Facility Director ensure development of a process to measure the effectiveness of Veterans Health Administration required suicide risk management training for all staff members who have completed it and to provide remedial training when needed.

Appendix A

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: February 10, 2015

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subj: Healthcare Inspection—Suicide Risk and Medical Management Issues, Hampton VA Medical Center, Hampton, Virginia

To: Director, Washington DC Office of Healthcare Inspections (54DC)
Director, Management Review Service (VHA 10AR MRS OIG Hotline)

1. I have reviewed the draft report for the Hampton VA Medical Center, Hampton, VA, and concur with the findings and recommendations.

2. If you have further questions, please contact Lisa Shear, QMO, VISN 6, at (919) 956-5541.

(original signed by:)

DANIEL F. HOFFMANN, FACHE
Network Director, VISN 6

Appendix B

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: February 9, 2015

From: Director, Hampton VA Medical Center, Hampton, VA (590/00)

Subj: Healthcare Inspection—Suicide Risk and Medical Management Issues, Hampton VA Medical Center, Hampton, Virginia

To: Director, VA Mid-Atlantic Healthcare Network (10N6)

1. I have reviewed the draft report and concur with the recommendations. The findings outlined in the OIG report reflect a thorough evaluation.

2. We have implemented processes to ensure that compliance to all processes are in effect.

(original signed by:)

Michael H. Dunfee, MHA
Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that contracted providers in all patient care areas complete the Veterans Health Administration's suicide risk management training.

Concur

Target date for completion: February 6, 2015

Facility response:

All facility Contracted Providers are in the process of completing the VHA's Suicide Risk Management for Clinicians training module located within the Talent Management System (TMS). 100% of all Contracted Providers scheduled through February 6, 2015 have completed VHA's Suicide Risk Management for Clinicians training. Effective February 6, 2015, no providers will provide clinical care unless he/she completed the VHA's Suicide Risk Management for Clinicians training. All new and returning Contract Providers will complete the VHA's Suicide Risk Management for Clinicians training on the first day of his/her duty. The Chief of Staff will track and report compliance to Medical Executive Board.

Recommendation 2. We recommended that the Facility Director ensure development of a process to measure the effectiveness of Veterans Health Administration required suicide risk management training for all staff members who have completed it and to provide remedial training when needed.

Concur

Target date for completion: July 6, 2015

Facility response:

The facility is conducting monthly random audits of seventy (70) medical records per month in Primary Care, Mental Health, and Emergency Room to ensure timely suicide ideation/behavior evaluations for at risk populations are completed. This monitor will be tracked at Mental Health Executive Council. The Chief of Staff will assign remedial training to those providers who are not compliant with completion of suicide risk assessments. Goal is 90% compliance.

Appendix C

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Katharine Foster, RN, Team Leader Julie Kroviak, MD Alan Mallinger, MD Randall Snow, JD Natalie Sadow, MBA

Appendix D

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