
**Department of Veterans Affairs**
**Office of Inspector General**

**Office of Healthcare Inspections**

**Report No. 15-05180-75**

# Healthcare Inspection

# Mental Health-Related Concerns W.G. Bill Hefner VA Medical Center Salisbury, North Carolina

**November 9, 2016**

**Washington, DC 20420**

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# Executive Summary

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted a review to assess allegations of inadequate mental health (MH) care of a specific patient and poor utilization of MH beds at the W. G. (Bill) Hefner VA Medical Center (facility) in Salisbury, NC. Initially, OIG received allegations concerning several deficiencies, including that patients requiring acute MH care were denied admission to the facility because the acute MH unit was constantly full and the chronic unit did not accept "overflow" patients. We requested the facility respond to the allegations. We found the facility's review and response to the initial allegations to be adequate.

Subsequently, OIG received additional allegations that a patient was discharged prematurely from the facility, was denied readmission due to a lack of acute MH beds, and subsequently committed suicide [because he was not admitted to the acute MH unit].

We did not substantiate the allegation that a patient was discharged prematurely from the facility, was denied readmission due to a lack of acute MH beds, and subsequently committed suicide. After being hospitalized for a week on the acute MH unit for suicidal ideation (SI) and other issues, the patient requested discharge. Psychiatrist A completed a suicide risk assessment and noted the patient to be at low risk for suicidal behaviors. The patient did not meet criteria for involuntary commitment and could not be held against his will. Facility staff instituted a reasonable discharge plan, and the patient was discharged the next day. An electronic High Risk for Suicide Patient Record Flag alerting staff to the need for increased monitoring was in place on the patient's medical record.

A few weeks later, the patient presented to the emergency department (ED) with SI and other issues. The acute MH unit was full, so facility staff followed unwritten protocol and admitted the patient to the medicine unit on one-to-one observation. When a bed became available on the acute MH unit 2 days later, the patient declined transfer and instead requested to be discharged. Psychiatrist C assessed the patient and determined the patient was at low risk for suicidal behaviors and noted that the patient was not appropriate for admission. Again, the patient could not be held against his will.

We did not substantiate the allegation that the patient committed suicide. The autopsy report attributed the cause of death to combined drug toxicity and classified the manner of death as accidental.

Although not part of the allegation, we found a lack of communication and coordination between ED staff, medical unit staff, Psychiatrist C, and the suicide prevention team during this patient's second hospitalization. However, we could not determine that this lack of communication and coordination would have changed the unfortunate outcome for this patient.

While we confirmed that the acute MH unit was frequently near capacity and that the chronic MH unit did not accept "overflow" patients, we did not substantiate the implied

inappropriateness of the condition. Facility leaders were aware of the problem and were actively recruiting for inpatient psychiatrists, which would permit full conversion of some chronic MH beds to acute MH beds.

We recommended that the Facility Director implement strategies to enhance communication and coordination across clinical areas for patients with High Risk for Suicide Patient Record Flags.

## Comments

The Veterans Integrated Service Network and the Facility Directors concurred with our recommendation and initiated a corrective action plan. (See Appendixes A and B, pages 10–12 for the Directors' comments.) We will follow up on the planned action until it is 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 a review to assess allegations of inadequate mental health (MH) care of a specific patient and poor utilization of MH beds at the W. G. (Bill) Hefner VA Medical Center (facility) in Salisbury, North Carolina. The purpose of the review was to determine whether the allegations had merit.

# Background

The facility provides medical, surgical, MH, and extended care services to more than 252,000 veterans living in a 24-county area of the Central Piedmont Region of North Carolina. The facility has two community based outpatient clinics located in Charlotte and Winston-Salem, NC. The facility is part of Veterans Integrated Service Network (VISN) 6.

The facility operates 23 acute MH beds, 20 chronic MH beds, and 55 Psychosocial Residential Rehabilitation Treatment Program/Substance Abuse Residential Rehabilitation Treatment Program (SARRTP) beds. The acute MH unit provides short-term inpatient treatment with a primary treatment goal of patient stabilization and discharge into continuing outpatient care or transfer to more specialized inpatient care as needed. The chronic MH unit serves patients requiring longer-term psychiatric hospitalization, including patients with severe and persistent mental illnesses or whose symptoms cannot be relieved in less than 15 days on the acute MH unit. The SARRTP allows patients with substance use disorders to receive intensive treatment in a supervised residential setting.[1]

## Suicide Risk Assessment and Patient Monitoring

Facility policy requires that a suicide risk assessment (SRA) be conducted for any patient with a primary diagnosis or primary complaint of an emotional or behavioral disorder.[2] An SRA is a formal clinical evaluation designed to elicit the necessary information to make a reasonable determination about a person's current risk for self-harm. The facility uses a templated SRA progress note that includes nine specific risk-related questions.[3]

The clinical provider is responsible for integrating all of the available assessment information, making a clinical judgment about the patient's current potential for suicide,

[1] Guide to VA Mental Health Services for Veterans and Families, page 14, http://www.mentalhealth.va.gov/VAMentalHealthGroup.asp, accessed January 25, 2016.
[2] Medical Center Memorandum 659-11-66, *Suicide Assessment, Intervention, and Documentation*, April 6, 2010. The policy expired on April 6, 2013, and has not been updated.
[3] The SRA includes questions about the patient's thoughts, intentions, plans, and means for self-harm as well as past history, family history, feelings of hopelessness and helplessness, socio-demographic factors, and psychosocial stressors.

and documenting the patient's risk for suicide as low, moderate, or high, as defined below:

- Low risk: A patient who currently has mild or passive thoughts of suicide with no suicide plan or intent to commit suicide is at low risk for suicide.

- Moderate risk: A patient who currently has frequent suicidal ideations (SI) with limited intensity and duration is at moderate risk for suicide. The patient may be thinking about suicide plans but has no current intent or means to carry out a plan.

- High risk: A patient who currently has frequent SI with high intensity and prolonged duration is at high risk for suicide. The patient has a suicide plan(s), access to means, and/or increasing suicidal intent.

The patient and staff implement treatment planning and safety measures in accordance with the patient's defined risk level.

Patient Record Flag

The Veterans Health Administration (VHA) established the High Risk for Suicide patient record flag (PRF) to alert providers about patients at high risk for suicide.[4] When a PRF is in place, providers receive a "pop-up" alert immediately upon accessing the patient's electronic health record (EHR). The PRF alerts providers to consider more frequent follow-up appointments, involve significant others in care planning, and limit access to means of harming oneself when possible. Clinicians are also responsible for developing suicide safety plans with high risk patients. A suicide safety plan is a prioritized list of coping strategies and sources of support that patients can use during or preceding suicidal crises.

Each VA medical center must appoint and maintain a Suicide Prevention Coordinator (SPC) with a full-time commitment to suicide prevention activities.[5] The SPC and other suicide prevention staff are responsible for working with providers to ensure high-risk patients with PRFs receive intensified monitoring and treatment and that follow-up occurs when patients miss appointments.

**Allegations:**

In 2015, OIG received an initial complaint alleging several deficiencies, including that patients requiring acute MH care were denied admission at the facility because the acute MH unit was constantly full and the chronic unit did not accept "overflow" patients. OIG requested that the facility respond to the allegations. Approximately one month later, the facility sent a response to the OIG that addressed the identified deficiencies

[4] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. The Directive expired on July 31, 2013 and has not been updated.
[5] The facility has a full time SPC.

and included the results of a MH bed utilization review and planned actions to increase acute MH bed capacity.

In the interim, OIG received allegations that a patient was discharged prematurely from the facility, was denied readmission due to a lack of acute MH beds, and subsequently committed suicide [because he was not admitted to the acute MH unit].

The OIG found the facility's review and response to the initial allegations to be adequate. This report addresses the new patient-specific allegation and the status of actions to improve access to acute MH care.

# Scope and Methodology

The scope included review of a specific patient's care and utilization of MH beds and was performed September 21, 2015 to February 23, 2016.

We reviewed VHA, VISN, and facility policies related to MH services and suicide prevention; bed census data; the patient's EHR; state reports on acute MH bed availability; and quality management reports.

We interviewed the complainant; the providers who cared for the patient during an inpatient stay; the SPC and the suicide prevention case manager (SPCM); MH and medical unit attending physicians and other personnel; and the facility Director, Chief of Staff, Chief of MH, Chief of the Emergency Department (ED), and others with knowledge about the patient or about relevant facility processes.

In the absence of current VA/VHA policy, we considered previous guidance to be in effect until superseded by an updated or re-certified Directive, Handbook, or other policy document on the same or similar issue(s).

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute 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 was a male in his mid-20s with a history of MH issues and lower back pain. The patient was hospitalized multiple times at the facility over the 3-year period prior to his death in 2015. The EHR reflected three reported or observed suicide attempts during the same time frame. The patient was referred to outpatient MH programs but often failed to attend prerequisite early recovery groups or left treatment prior to program completion.

The patient was admitted to the facility's acute MH unit in 2015 (Day 1). The attending psychiatrist (Psychiatrist A) entered a Suicide Risk Management Consult the same day, noting that the patient reported he had ingested a mixture of drugs the previous day in a suicide attempt. Four days later (Day 5), the patient met with Program A social worker to discuss treatment options. The patient disagreed with and refused to accept the recommended treatment and group information for Program A. The EHR reflected that, when leaving the meeting, the patient stated he was "going to die" if he did not go directly into a different program, Program B. The Program A social worker noted that the patient might need to be more stable before being able to benefit from Program B.

On Day 8, the patient requested to be discharged. The EHR reflected that the patient reported his "mood was good" and that he "never made any statements relating to suicidal ideation, and denies that he had any suicidal ideation." The patient also reported that he felt safe and would not hurt himself. Psychiatrist A noted that the patient did not meet North Carolina Involuntary Commitment criteria[6] at that time, but decided to monitor the patient over night for safety.

On Day 9, the patient completed a Suicide Safety Plan, and Psychiatrist A completed an SRA and determined the patient was at low risk for suicidal behaviors. The patient again denied suicidal or homicidal ideation. The treatment team felt the patient no longer required inpatient care, and he did not meet North Carolina Involuntary Commitment criteria. The patient's discharge plan included disposition to home with continuance on antidepressant, antipsychotic, and pain medications. The patient was scheduled for a telephone follow-up appointment the day after discharge (Day 10) and an outpatient MH appointment with Psychiatrist B on Day 18.

On Day 10, the SPC placed a High Risk for Suicide PRF in the patient's EHR as a precautionary measure because of the patient's reported suicide attempt 9 days earlier. The following day, the SPC sent a letter to the patient explaining the reason for the PRF, identifying who to contact in an emergency, and outlining care to be provided over the next few weeks. Also on Day 10, a nurse attempted to contact the patient via telephone without success. On Day 11, a Program A social worker attempted to contact

[6] Section 122C-288(j) provides that in order to support an inpatient commitment order, the court shall find by clear, cogent and convincing evidence that the respondent is mentally ill and dangerous to self or dangerous to others. N.C. Gen.Stat. § 122C-268(j); *see also* N.C. Gen.Stat. § 122C-3(11)a (defining "dangerous" to self) and § 122C-3(11)b (defining "dangerous" to others).

the patient without success, and on Day 12, the SPCM attempted to contact the patient, also without success. The patient did not attend his Day 18 MH appointment. Psychiatrist B, in accordance with policy, attempted to contact the patient, but the patient did not return the phone call.[7]

On Day 22, the patient presented to the Primary Care Clinic complaining of back pain, requesting a refill of his pain medication, and a letter for the homeless shelter. The primary care provider advised the patient that he would not refill the medication (as the patient had received a month's supply of this pain medication 2 weeks previously) and referred the patient back to Psychiatrist A who had originally prescribed the pain medication.

On Day 26, the patient attended a Homeless Program Stand Down[8] and briefly engaged with Psychiatrist A in the hallway. During this exchange, the patient asked for a refill of pain medication until he could meet with his primary care provider. Psychiatrist A prescribed a 3-day supply and documented that the patient denied SI. The patient's affect was noted to be euthymic and stable.

On Day 33, the patient told his MH case manager that he planned to contact Program A social worker to attend that program. On Day 39, the patient met with Program A social worker and agreed to attend a 12-week group.

On Day 41, the patient presented to the ED for SI and other issues. The ED physician completed an SRA and documented that the patient was at moderate risk for suicidal behavior but not acutely dangerous to himself. Due to the lack of acute MH beds, the patient was admitted to the medical unit and placed on one-to-one[9] observation. The admitting physician noted "prognosis poor." The admitting provider placed a MH consult, continued the patient's antipsychotic and antidepressant medications, and kept the patient on one-to-one observation. About 16 hours after admission, a different medical unit physician documented the plan to transfer the patient to the MH unit when a bed became available.

On Day 43, the patient requested to be discharged rather than transferred to the acute MH unit. Psychiatrist C, who responded to the MH consult of the previous day, wrote that the patient was competent to make his own decisions. Psychiatrist C further documented, "Veteran is not appropriate for admission…at this time. No suicidal or homicidal ideation." Psychiatrist C completed an SRA and determined the patient was at low risk for suicidal behavior. The patient was discharged on the same antidepressant, antipsychotic, and pain medications he had been receiving, although it

[7] The SPC's letter notified the patient that if he did not show for his appointment, then the facility would initiate a WELLNESS CHECK. "A WELLNESS CHECK means we must contact the local police to go to your home to check on you to be sure you are okay." While we found no evidence that a WELLNESS CHECK was initiated immediately following the patient's no-show, the patient presented to the primary care clinic 4 days later.
[8] Stand Downs are events providing supplies and services to homeless Veterans, such as food, shelter, clothing, health screenings, and referrals for other assistance such as health care, housing solutions, employment, substance use treatment, and MH counseling.
[9] VHA defines one-to-one observation as the constant observation of the patient by staff.

did not appear that he filled the prescriptions at the facility's pharmacy. According to the discharge plan, the patient was to follow up with his primary care and MH providers in 1–2 weeks. However, no follow-up appointments were scheduled.

On Day 44, a facility social worker received notification that the patient had died.

# Inspection Results

**Issue 1: Quality of MH Care**

We did not substantiate that a patient was discharged prematurely from the facility, was denied readmission due to a lack of acute MH beds, and subsequently committed suicide [because he was not admitted to the acute MH unit].

*Hospital Discharge #1*

We found no evidence that the patient was discharged prematurely from the Day 1 through 9 hospitalization.

The patient was admitted to the facility's acute MH unit. Although the patient initially demanded placement into a particular program, Program B, he declined to participate in the prerequisite group sessions and requested discharge. The patient told the treatment team that his mood was good, and he denied suicidal or homicidal ideations. As a precautionary measure, the patient was monitored overnight.

On Day 9, Psychiatrist A completed an SRA, noted that the patient was at low risk for suicidal behavior, and documented that the patient did not meet involuntary commitment criteria, which would generally require the court to find the patient was a danger to himself or others. Because the patient requested discharge, and could not be held against his will, clinical staff had no choice but to honor his request for discharge. The patient had a suicide safety plan and follow-up appointments in place at the time of discharge. A High-Risk for Suicide PRF was placed the following day as a precautionary measure because of the patient's reported suicide attempt 9 days earlier.

*Hospital Admission #2*

We confirmed that the patient was admitted to a medical unit at the time of hospital admission #2 because the acute MH unit did not have vacant beds. We did not substantiate, however, that this action was improper or that it negatively affected the patient's condition or course of treatment.

Facility staff told us that when the acute MH unit was full, patients were admitted to another VA facility, to a local community hospital, or to the medicine unit with one-to-one observation until a bed became available on the acute MH unit.

When the patient came to the ED on Day 41, he was appropriately admitted to the medicine unit and placed on one-to-one observation because of the lack of acute MH beds. When the patient requested discharge rather than be transferred to the acute MH

unit, Psychiatrist C assessed the patient and determined that the patient was at low risk for suicidal behavior. Although an acute MH bed was available, Psychiatrist C noted that the patient was not appropriate for admission and that the patient was competent to make his own decisions.

*Alleged Suicide*

We did not substantiate that the patient committed suicide. The patient was found unresponsive on Day 44. There was "nothing suspicious at the scene," but the cause of death was unknown and not declared by first responders. The autopsy report attributed the cause of death to combined drug toxicity and classified the manner of death as accidental.

*Suicide Prevention Activities*

While we did not identify significant quality of care issues in this case, we found a lack of communication and coordination between the ED, medical unit staff, Psychiatrist C, and the Suicide Prevention (SP) team related to Hospital #2 admission and discharge. Specifically,

- The SPC and SPCMs were not notified by ED or inpatient medical unit staff when patients with PRFs were treated in those respective areas for SI or other MH-related conditions. Staff told us that the facility did not have an electronic alert to SP team members when patients with PRFs were admitted or discharged, nor were SP staff routinely included as cosigners on relevant progress notes. Some staff we interviewed were not fully aware of the SP team and its function.

- An SP team member was not fully aware of his/her role to meet with this high-risk patient or the clinical team in both the inpatient and outpatient setting.

- Although Psychiatrist C appropriately assessed the patient prior to discharge, he did not consult with, or at least notify, the SP team of the plan.

While the facility missed several opportunities to follow up to provide enhanced oversight in the last month of this patient's life, we could not determine whether more aggressive intervention would have changed the unfortunate outcome.

**Issue 2: Utilization of MH Beds**

While we confirmed that the acute MH unit was frequently near capacity and that the chronic MH unit did not accept "overflow" patients, we did not substantiate the implied inappropriateness of the condition. Several factors determine the staffing needs of the acute and chronic MH units. The two units are staffed differently, and it would be

improper and potentially unsafe to place a patient with acute MH needs on a chronic MH unit.[10]

From January to August 2015, the acute MH unit was often near capacity. The facility did not have a written policy or protocol to disposition acutely mentally ill patients requiring hospitalization when no acute MH beds were available. However, staff we interviewed consistently reported that when acute MH beds were not available at the facility, they:

- determined if a current in-house acute MH patient was stable enough to move to a chronic MH bed; or
- placed the patient on an inpatient medical unit, if a comorbid medical condition existed, pending transfer to an acute MH bed when available; or
- transferred the patient to an acute MH bed at another VHA facility within the VISN; or
- attempted to transfer the patient to a private-sector MH facility.

Staff also fairly consistently reported that it was difficult to transfer acutely mentally ill patients to other VHA facilities or private-sector facilities and that these options were rarely used.[11]

Facility leaders acknowledged that the number of acute MH beds was insufficient to meet demand and, in the summer of 2014, submitted a proposal to the VISN for funding that would permit conversion of nine chronic MH beds to acute MH beds. The VISN did not fund the proposal, but in the 2nd quarter FY 2015, the facility designated seven Veterans Access, Choice, and Accountability Act of 2014[12] nursing positions to MH in anticipation of the increase in acute MH beds. Those nurses were hired and are on duty. However, the facility has been unsuccessful in recruiting the additional psychiatrists needed to support the expansion of the acute MH beds. As of September 2016, that effort was ongoing.

During the course of our review we did not identify, nor were we told of, other patients experiencing adverse outcomes due to a lack of acute MH beds at the facility.

[10] These factors include patient acuity levels, behavioral issues, 1:1 for suicide observation status and other safety concerns, monitoring requirements based on Suicide Precaution Levels, hourly rounding, treatment team attendance, transporting/accompanying patients to off-unit or off-station appointments, and staff being pulled to a non-MH unit to provide 1:1 observation for a MH patient.
[11] For the period June 1 through November 30, 2015, the facility transferred 10 patients requiring acute MH care from the ED to another VHA medical center, and did not transfer any acutely mentally ill patients to private-sector hospitals for MH care.
[12] Veterans Access, Choice, and Accountability Act of 2014; *http://www.va.gov/opa/choiceact/documents/Veterans-Day-VACAA-Progress-Fact-Sheet.pdf*

# Conclusions

We did not substantiate the allegation that a patient was discharged prematurely from the facility, was denied readmission due to a lack of acute MH beds, and subsequently committed suicide. After being hospitalized for a week on the acute MH unit, the patient requested discharge. Psychiatrist A completed an SRA and noted the patient to be at low risk for suicidal behaviors. The patient did not meet criteria for involuntary commitment and could not be held against his will. Facility staff instituted a reasonable discharge plan and the patient was discharged a day later.

Approximately 4 weeks later, the patient presented to the ED with SI and other issues. The acute MH unit was full, so facility staff followed unwritten protocol and admitted the patient to the medicine unit on one-to-one observation. When a bed became available on the acute MH unit 2 days later, the patient declined transfer and instead requested to be discharged. Psychiatrist C assessed the patient and determined the patient was at low risk for suicidal behaviors and noted that the patient was not appropriate for admission. Again, the patient could not be held against his will.

We did not substantiate the allegation that the patient committed suicide. The autopsy report attributed the cause of death to combined drug toxicity, and classified the manner of death as accidental.

Although not part of the allegation, we found a lack of communication and coordination between ED staff, medical unit staff, Psychiatrist C, and the SP team during this patient's second hospitalization. While the facility missed several opportunities to follow up to provide enhanced oversight in the last month of this patient's life, we could not determine whether more aggressive intervention would have changed the unfortunate outcome.

While we confirmed that the acute MH unit was frequently near capacity and that the chronic MH unit did not accept "overflow" patients, we did not substantiate the implied inappropriateness of the condition. Facility leaders were aware of the problem and were actively recruiting for inpatient psychiatrists, which would permit full conversion of some chronic MH beds to acute MH beds.

# Recommendation

1. We recommended that the Facility Director implement strategies to enhance communication and coordination across clinical areas for patients with High Risk for Suicide Patient Record Flags.

**Appendix A**

# VISN Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** March 31, 2016

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

**Subj:** Healthcare Inspection—Mental Health-Related Concerns, W. G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina

**To:** Director, Atlanta Office of Healthcare Inspections (54AT)
Director, Management Review Service (VHA 10E1D MRS Action)

1. The attached subject report is forwarded for your review and further action. I reviewed the response of the W. G. (Bill) Hefner VA Medical Center (VAMC), Salisbury, North Carolina and concur with the facility's recommendations.

2. If you have further questions, please contact Kaye Green, Director, Salisbury VAMC, at (704) 638-3344.

*(original signed by:)*
Joseph Edger, Deputy Network Director *for*
DANIEL F. HOFFMANN, FACHE

**Appendix B**

# Facility Director Comments

**Department of Veterans Affairs**

# Memorandum

**Date:** March 23, 2016

**From:** Director, W. G. (Bill) Hefner VA Medical Center (659/00)

**Subj:** Healthcare Inspection—Mental Health-Related Concerns, W. G. (Bill) Hefner VA Medical Center, Salisbury, North Carolina

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

1. I have reviewed the draft report of the Office of Inspector General and I concur with the recommendations.
2. I have included my response in the attached Director's Comments.
3. Please contact me if you have any questions or comments.

*(original signed by:)*
Lynette L. Baker, Associate Director *for*
KAYE GREEN, FACHE

# Comments to OIG's Report

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

**OIG Recommendation**

**Recommendation 1.** We recommended that the Facility Director implement strategies to enhance communication and coordination across clinical areas for patients with High Risk for Suicide Patient Record Flags.

Concur

Target date for completion: May 1, 2016

Facility response:

Medical Center Memorandum (MCM) 111M-11 Suicide Assessment, Intervention, and Documentation is currently under revision to ensure Suicide Prevention staff are notified when a patient who is flagged High Risk for Suicide is admitted to an inpatient unit or visits the Emergency Department. Revision to the MCM will be reviewed with all applicable staff. Suicide Prevention Case Managers (SPCM) will be notified via view alert when a patient is admitted to an inpatient unit. The SPCM will be required to contact the treatment team and/or patient to assist in suicide prevention strategies. When patients who are flagged High Risk for Suicide visit the Emergency Department, the triage nurse is responsible for contacting the assigned mental health nurse. The Mental Health nurse will support mental health care while the patient is in the Emergency Department and be responsible for communicating the encounter to the Suicide Prevention team. Upon notification, the SPCM will be required to follow up with the patient if the patient is treated and released. The Office of Performance & Quality will monitor electronic medical records to ensure suicide prevention team involvement in the care of patients presenting to the ED and/or admitted to the inpatient units. The audits will be collected each month to ensure at least 90% compliance for three consecutive months. Results of the audits will be reported to the Clinical Executive Board for oversight.

OIG Update as of September 30, 2016: The facility issued MCM 656-11M-11 on May 5, 2016, which includes communication requirements when patients who are flagged High Risk for Suicide are admitted to an inpatient unit or visit the Emergency Department. The facility provided electronic health record audit data reflecting compliance with the revised communication requirements, as follows: July (76 percent), August (95 percent), and September (91 percent). This recommendation will remain open until the facility achieves three consecutive months of at least 90 percent compliance.

**Appendix C**

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
| **Contact** | For more information about this report, please contact the OIG at (202) 461-4720. |
| **Contributors** | Victoria Coates, LICSW, MBA, Team Leader<br>Sherry Purvis-Wynn, RN, MS<br>Joanne Wasko, LCSW<br>Thomas Wong, DO<br>Anita Pendleton, AAS |

**Appendix D**

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