US DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Noncompliance with Suicide Prevention Policies at the Overton Brooks VA Medical Center in Shreveport, Louisiana

Healthcare Inspection | **23-02898-195** | **July 10, 2024**

BE A
VOICE FOR
VETERANS
REPORT WRONGDOING
vaoig.gov/hotline | 800.488.8244

OUR MISSION

To serve veterans and the public by conducting meaningful independent oversight of the Department of Veterans Affairs.

CONNECT WITH US

Subscribe to receive updates on reports, press releases, congressional testimony, and more. Follow us at @VetAffairsOIG.

PRIVACY NOTICE

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection at the Overton Brooks VA Medical Center (facility) in Shreveport, Louisiana, after receiving allegations that facility staff were not following the Veterans Health Administration (VHA) Suicide Prevention Program policy.[1]

The OIG evaluated facility compliance with VHA suicide prevention policy and guidance in the care of two patients, one who died by suicide (Patient A) and one who was admitted after a suicide attempt (Patient B). The OIG identified numerous failures to comply with suicide prevention policies and guidance.

Suicide Prevention

VHA's Suicide Prevention Program encompasses many initiatives, including the Veterans Crisis Line (VCL), suicide risk screening and assessment, high risk for suicide patient record flags (PRFs), and the behavioral health autopsy program (BHAP).[2] Established in 2007, VCL is intended to provide veterans with "predictable, consistent, and accessible crisis intervention services."[3] A VCL responder conducts crisis intervention and initiates a referral (VCL request) through Medora, VCL's web-based record system, to a VA medical facility suicide prevention staff member for follow-up (VCL request response calls).[4] Facility suicide prevention teams are subject matter experts for matters related to suicide.

Patient Case Summaries

Patient A initiated care with the facility in mid-spring 2023, at which time the patient requested assistance with housing. In late spring 2023, the patient called the VCL and communicated a need for help finding housing; while talking to a VCL responder, the patient expressed suicidal ideation and access to a firearm. A suicide prevention staff member made multiple attempts after this call to reach the patient and four days later, the suicide prevention staff member spoke with the patient and the patient's spouse. Less than a week later, a social worker called the patient to assist with housing and initiated a welfare check after the spouse stated there was an emergency

[1] The OIG also reviewed an allegation that a patient needed but did not receive assisted living. The allegation was not substantiated.

[2] VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," December 2022.

[3] VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center*, May 26, 2020, amended December 8, 2022.

[4] VHA Directive 1503(2). A VCL responder is a VCL staff member. VCL responders and suicide prevention team members document information and actions taken in Medora when responding to VCL requests.

in the home. The dispatcher who responded to the call informed the social worker that the patient had completed suicide by firearm.

Patient B called the VCL in early spring 2023, reporting depression and suicidal ideation with a plan to overdose on medication, and attempted suicide later that day. The patient was then brought via ambulance to the facility and admitted to the intensive care unit (ICU).[5] While in the ICU, the patient attempted suicide twice. The patient was discharged to a community long term acute care facility in mid-spring 2023. During the patient's facility hospitalization, suicide prevention staff completed a high risk for suicide PRF. After two failed attempts to reach the patient in the month following discharge, the suicide prevention team determined that there was a reduction in Patient B's clinical risk, and removed the high risk for suicide PRF.

Failures in Suicide Risk Screening, Assessment, and Documentation

The OIG substantiated that a suicide prevention staff member did not screen or assess Patient A for suicide risk during a VCL request response call and missed important information from Medora.[6] Per VHA policy, clinicians must screen patients for suicide risk using the Columbia-Suicide Severity Rating Scale (C-SSRS) when clinically indicated and, if the screen is positive, licensed independent providers (LIPs) must complete the Comprehensive Suicide Risk Evaluation (CSRE).[7] VHA also requires suicide prevention staff to reassess patients "for any potential risk," to include suicide during facility VCL request response calls.[8]

In follow-up to the patient's VCL call, the suicide prevention staff member made two telephone contact attempts before speaking with Patient A and Patient A's spouse in late spring 2023. The suicide prevention staff member reported reviewing Medora but stated "unfortunately, I missed some crucial details." The suicide prevention staff member denied completing a C-SSRS and asking Patient A about access to lethal means. When asked about assessing suicide risk, the suicide prevention staff member reported "We [do not] do [C-SSRSs] . . . on those calls" and described asking patients, including Patient A, "do you want to hurt yourself? Do you want to kill yourself?" However, the suicide staff member failed to include any information about suicide risk or assessment in Medora or the patient's electronic health record (EHR).

The OIG concluded that the suicide prevention staff member failed to recognize critical information documented in Medora, including the patient's access to lethal means and, although

[5] A VCL responder referred the patient to the facility suicide prevention team, however, the patient had already been admitted to the facility at the time of the suicide prevention staff member's VCL request response attempt.

[6] Information from Medora is not transferred to the EHR until the request is completed.

[7] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)." For CSRE completion, VHA identifies LIPs as clinicians who "hold state licensure and are included in local bylaws as an independent practitioner."

[8] VHA Directive 1503(2); VA Suicide Risk Identification Strategy, "Staff Specific Guidance," March 22, 2023.

clinically indicated, the suicide prevention staff member did not utilize the C-SSRS and CSRE to screen and assess Patient A's suicide risk.

The OIG also substantiated that the suicide prevention staff member documented each contact attempt in response to Patient A's and Patient B's VCL requests in Medora, but did not document the contact attempts in the EHR. VHA requires suicide prevention staff to document each contact attempt in both Medora and the EHR (dual documentation).[9] The suicide prevention staff member reported awareness of the dual documentation requirement and stated, "unfortunately, I just [did not] do it." Failure to document contact attempts after patients call the VCL inhibits clinicians' ability to make informed patient-care decisions.

The OIG substantiated that another suicide prevention staff member did not complete a BHAP chart review and a family interview contact form (FIT-C) timely following Patient A's death by suicide.[10] VHA policy requires that suicide prevention staff, within 30 days of becoming aware of a veteran suicide, complete the BHAP chart review, contact the next of kin, and complete the FIT-C form.[11]

The BHAP chart review for Patient A was completed 66 days after the suicide prevention team was aware of the patient's death by suicide and the other suicide prevention staff member documented telephone contact with Patient A's spouse four days later. During interviews, the suicide prevention staff member identified workload demands and work prioritization as reasons for the lack of timely documentation.

Failures in Performance Oversight and Clinical Case Reviews

The OIG substantiated that the suicide prevention program manager failed to take corrective action to address suicide prevention staff performance deficiencies and failed to complete and document review of required clinical case review elements for VCL request responses. VHA directs facility managers to "complete regular performance reviews of . . . management of VCL [r]equests," which entails a clinical case review of required documentation including assessment of patients for risk, actions taken to address issues in VCL requests, and documentation of VCL request response attempts in Medora and the EHR.[12]

[9] VHA Directive 1503(2).

[10] The BHAP chart review is "[a] comprehensive review of a [patient's] EHR to identify contributory factors to suicide." A family interview is completed to understand the circumstances impacting a veteran's life prior to death by suicide. VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," December 2022.

[11] VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021; VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide."

[12] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Enhancing Management and Oversight of Veterans Crisis Line (VCL) Requests," memorandum to VISN Directors, VISN Chief Medical Officers and VISN Chief Mental Health Officers, March 15, 2023; VHA Directive 1503(2).

The OIG reviewed documentation of the suicide prevention program manager's completed performance reviews and found that the manager's reviews did not include review of staff documentation of patients' risk assessments, "actions . . . taken to resolve issues," or dual documentation. The suicide prevention program manager told the OIG that staff members were not addressing why patients called the VCL nor completing dual documentation. When asked about corrective actions taken, the suicide prevention program manager acknowledged speaking with suicide prevention staff members but was unable to provide any documented evidence of the discussions or other corrective actions taken to address the identified VCL response deficiencies.

The OIG concluded that the suicide prevention program manager failed to address deficiencies with VCL request response documentation and failed to document conducting clinical case reviews as required by VHA policy.

Registered Nurse Dual Assignments

The OIG found that an ICU registered nurse served as Patient B's primary nurse and one-to-one observation staff member following Patient B's two inpatient suicide attempts. A facility September 2020 policy states "[s]taff providing [one-to-one] observation should only be observing one patient at a time and have no other responsibilities during the assignment." The Joint Commission requires hospitals monitor for effectiveness of management of suicidal patients as per policy.[13]

During interviews with the OIG, an ICU registered nurse caring for Patient B reported serving as both the one-to-one observation staff member and the patient's assigned registered nurse after Patient B's inpatient suicide attempts and that a dedicated one-to-one observation staff member was assigned the following morning. ICU registered nurses and a nursing leader reported that ICU registered nurses regularly act as both a registered nurse assigned to a patient and as the same patient's one-to-one observation staff member.

Facility leaders told the OIG that the facility was working to clarify procedures for one-to-one observation, including staff assignments. During the inspection, the Associate Director for Patient Care Services provided the OIG with a standard operating procedure, signed October 2, 2023, which clarified that a registered nurse observing a patient may not also be assigned as the patient's primary nurse.[14]

[13] Facility MCP 11-22, *Suicide Prevention Policy*, September 24, 2020; The Joint Commission E-dition, *National Patient Safety Goals*, 15.01.01.

[14] Facility Standard Operating Procedure 118-61, *Telesitter Monitoring Close Observation and Continuous Observation*, September 1, 2023; Facility Standard Operating Procedure 118-61, *Telesitter Monitoring Close Observation and One to One Observation*, June 27, 2022.

The OIG concluded that Patient B's registered nurse had dual assignments as one-to-one observation staff member and primary nurse, which contradicted facility policy.

Failure to Ensure Follow-up After Patient Record Flag Placed

The OIG substantiated that the facility failed to follow policy to ensure that Patient B had at least one mental health appointment monthly after a high risk for suicide PRF placement. The OIG also substantiated suicide prevention staff failed to consult with other treatment team members prior to inactivation of Patient B's PRF, as required by policy.[15]

A high risk for suicide PRF should be considered when making treatment and scheduling decisions.[16] Per VHA policy, the suicide prevention team, in conjunction with other facility healthcare professionals, ensures that patients with an active high risk for suicide PRF have at least one mental health appointment monthly until PRF inactivation.[17] Facility policy states "[t]he decision regarding . . . inactivation of the [high risk for suicide] PRF is done in conjunction with the Suicide Prevention Team, Veteran and/or family members, and the Veteran's treatment team."[18]

Upon review of the EHR, the OIG found that a suicide prevention staff member placed Patient B's high risk for suicide PRF in spring 2023 during the patient's hospitalization, and that a different suicide prevention staff member removed the PRF 82 days after placement without documentation of consultation. While aware that clinical care providers were to be included in patient PRF reviews, the suicide prevention program manager told the OIG that no provider was consulted prior to inactivating Patient B's PRF but could not explain why. Additionally, there was no evidence of an outpatient mental health appointment or mental health care for Patient B through late summer 2023.

The OIG concluded that facility staff failed to ensure that Patient B, who had an active high risk for suicide PRF, had a mental health appointment. Additionally, facility staff and leaders were

[15] Facility MCP 11-22; VHA Notice 2022-06, "Inactivation Process for Category I High Risk for Suicide Patient Record Flags," July 21, 2022. This Notice was rescinded with publication of VHA Directive 1166, *Patient Record Flags*, November 6, 2023. VHA Directive 1166 contains similar language related to the management of PRFs. VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. This Directive was rescinded with publication of VHA Directive 1166. Suicide prevention coordinators are responsible for maintaining high risk for suicide PRFs.

[16] VHA Directive 2008-036. This Directive was rescinded with the publication of VHA Directive 1166, *Patient Record Flags,* November 6, 2023. VHA Directive 1166 contains similar language regarding the high risk for suicide PRF definition.

[17] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Update to High Risk for Suicide Patient Record Flag (HRS-PRF) Changes," memorandum, to Veterans Integrated Services Network (VISN) Directors, VISN CMOs, VISN Chief Mental Health Officers, October 5, 2021. This memorandum was rescinded with the publication of VHA Directive 1166, *Patient Record Flags,* November 6, 2023. VHA Directive 1166 contains similar language related to the requirement for mental health appointments.

[18] Facility MCP 11-22.

unclear about who had responsibility to ensure mental health care for Patient B following discharge. Patient B's PRF was inactivated without input from the patient's treatment team. Lack of input from the treatment team involved in patients' care may lead to inappropriate PRF inactivation for patients at high risk for suicide.

Inadequate Suicide Prevention Staffing

During the inspection, the OIG identified an additional concern with suicide prevention team staffing levels and learned of delays in posting vacant positions. Per VHA policy, each medical facility must maintain one suicide prevention coordinator. However, Veterans Integrated Service Networks (VISNs) are expected to "encourage" hiring of additional suicide prevention staff using a workload-based staffing model.[19] The facility's workload-based staffing model indicated a need for 3.87 full-time equivalent suicide prevention coordinators, not including the suicide prevention program manager.

At the time of the inspection, the facility Suicide Prevention Program had three clinical staff members, including the program manager.[20] An additional suicide prevention coordinator began employment in early fall 2023. The Facility Director approved hiring four more full-time suicide prevention coordinators, but as of November 20, 2023, those positions had not posted as human resources staff had not completed the announcements.[21]

The OIG determined that the facility had insufficient suicide prevention staff and identified a delay in posting suicide prevention coordinator positions. The OIG is concerned that insufficient suicide prevention staffing limits the facility's ability to care for veterans at risk of suicide.

The OIG made one recommendation to the VISN Director related to suicide prevention staff posting and identification of recruitment opportunities.

The OIG made seven recommendations to the Facility Director related to compliance with suicide prevention policy as well as one-to-one observation staff assignments.

[19] VHA Directive 1160.07. VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Guidance for Reporting and Monitoring of Suicide Prevention Program (SPP) Staffing," memorandum to VISN Directors, August 8, 2023.

[20] The suicide prevention program manager entered the position in late year 2022.

[21] The Facility Director approved hiring four suicide prevention coordinators in August 2023.

VA Comments and OIG Response

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

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

Contents

Abbreviations

BHAP	behavioral health autopsy program
CSRE	Comprehensive Suicide Risk Evaluation
C-SSRS	Columbia-Suicide Severity Rating Scale
EHR	electronic health record
FIT-C	family interview contact form
ICU	intensive care unit
LIP	licensed independent provider
OIG	Office of Inspector General
PRF	patient record flag
VCL	Veterans Crisis Line
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted an inspection at the Overton Brooks VA Medical Center (facility) in Shreveport, Louisiana to review facility staff compliance with Veterans Health Administration (VHA) Suicide Prevention Program policy as well as evaluate an allegation that a patient needed, but did not receive, assisted living.[1]

Background

The facility is part of Veterans Integrated Service Network (VISN) 16, the South Central VA Health Care Network, and consists of one inpatient hospital and three outpatient clinics. The facility provides comprehensive healthcare, including mental health and primary care, to patients in Louisiana, Southern Arkansas, and East Texas.

Suicide Prevention

VA has designated suicide prevention as the top clinical priority.[2] While suicide is broadly recognized as a serious public health problem, veterans have "higher than average" rates of suicide. In 2021, the rate for veteran suicide was 71.8 percent higher than for non-veteran adults.[3] VA has identified a variety of risk factors for suicide, including availability of lethal means and a prior suicide attempt.[4]

VHA and the Office of Mental Health and Suicide Prevention have issued policies, memoranda, and program guides for VHA's suicide prevention initiatives and suicide prevention staffing. VHA's Suicide Prevention Program encompasses many initiatives, including the Veterans Crisis

[1] "Geriatrics and Extended Care," VA, accessed October 16, 2023, www.va.gov/geriatrics/. Assisted living facilities provide a rented room or apartment where there is a trained caregiver available to help with activities of daily living such as bathing and getting dressed.

[2] "Suicide Prevention – Mental Health," VA, accessed October 12, 2023, https://www.mentalhealth.va.gov/suicide_prevention/index.asp.

[3] VHA Office of Mental Health and Suicide Prevention, *2023 National Veteran Suicide Prevention Annual Report*, November 2023. This rate was calculated after adjusting for age and sex differences; "Facts About Suicide," Centers for Disease Control and Prevention (CDC), accessed October 12, 2023, https://www.cdc.gov/suicide/facts/index.html.

[4] VHA Office of Mental Health and Suicide Prevention, *National Strategy for Preventing Veteran Suicide, 2018 – 2028*; VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. Lethal means are objects, including medications and firearms, "that can be used to engage in suicidal and non-suicidal self-directed violence."

Line (VCL), suicide risk screening and assessment, high risk for suicide patient record flags (PRFs), suicide behavior reporting, and the behavioral health autopsy program (BHAP).[5]

Facility suicide prevention teams are subject matter experts for matters related to suicide, including prevention, intervention, and suicide death and behavior reporting, and are responsible for facilitating implementation of the Suicide Prevention Program.[6] Suicide prevention teams' size and composition vary across VA facilities.

Veterans Crisis Line

Established in 2007, the VCL is intended to provide veterans with "predictable, consistent, and accessible crisis intervention services."[7] A VCL responder conducts crisis intervention for veterans, service members, and their family members who contact the VCL through telephone, online chat, and text.[8] VCL responders may refer individuals to a local suicide prevention team for follow-up or initiate a dispatch of emergency services, as needed.[9] VCL responders initiate referrals (VCL requests) to a VA facility suicide prevention staff member for follow-up, as appropriate. In response to VCL requests, VA facility suicide prevention staff conduct VCL request response calls during which patients are reassessed for suicide risk, when clinically indicated, and patient needs, as identified in the VCL request, are addressed.[10] Resolving patient needs may include coordination with other members of the patient's healthcare team.

Prior OIG Reports

An OIG report, published on June 6, 2022, included one recommendation to the VA Under Secretary for Health regarding regular regional and local management reviews of VCL information in the electronic health record (EHR) to ensure appropriate referral follow-up.[11] The OIG closed this recommendation on May 1, 2023.

[5] VHA Directive 1503(2), *Operations of the Veterans Crisis Line Center*, May 26, 2020, amended December 8, 2022; VHA Suicide RISK ID Strategy, "Suicide Risk Identification," September 21, 2021; VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Guide," December 2022. The BHAP collects information such as risk factors and interventions related to all veteran deaths by suicide reported to VA facilities. The BHAP includes a chart review, a family interview, and a suicide prevention staff member interview.

[6] Throughout this report, the OIG refers to suicide prevention staff, which include the suicide prevention program manager, suicide prevention coordinator, and suicide prevention case manager.

[7] VHA Directive 1503(2).

[8] VHA Directive 1503(2). A "VCL responder is a VCL staff member."

[9] VHA Directive 1503(2).

[10] VHA Directive 1503(2).

[11] VA OIG, *Suicide Prevention Coordinators Need Improved Training, Guidance, and Oversight*, Report No. 20-02186-78, June 6, 2022.

Allegations and Related Concerns

The OIG conducted a healthcare inspection in response to two anonymous complaints that alleged facility staff were not following VHA suicide prevention policies. Both complaints named Patient A, who had died by suicide; one complaint named Patient B, who had attempted suicide. Specifically, the complaints alleged facility noncompliance with VHA's suicide prevention policy regarding

- completion of suicide risk screenings and evaluations,
- use of high risk for suicide PRFs, and
- completion of VCL requests.

Additionally, one complaint identified that Patient A needed, and did not receive, assisted living.

During the course of the inspection, the OIG identified additional concerns regarding registered nurse dual assignments and suicide prevention staffing.

Scope and Methodology

The OIG initiated the healthcare inspection on July 6, 2023, and conducted a site visit August 29 through 31, 2023.

The OIG reviewed relevant VHA directives, memoranda, program guides, facility policies and procedures, human resources documents, and electronic mail correspondence. The OIG also reviewed facility compliance with VHA suicide prevention policy in the care of Patient A and Patient B and evaluated facility staff actions in response to Patient A's request for assisted living. Further, the OIG reviewed relevant Medora and EHR entries for Patient A and Patient B.[12]

The OIG interviewed facility staff and leaders as well as VISN mental health and VISN suicide prevention leaders.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

The OIG substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take

[12] Medora is a web-based application. VCL responders can initiate a referral (VCL request) to suicide prevention team members. VCL responders and suicide prevention team members document information and actions taken when responding to VCL requests. The OIG did not review non-VHA medical records unless available in the patients' EHRs.

place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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

Patient Case Summaries

Patient A

Patient A was in their 80s with a medical history significant for stroke, diabetes, high cholesterol, and atrial fibrillation who died by suicide via firearm late spring 2023.[13]

The patient initiated care with the facility via a primary care visit in mid-spring 2023, at which time the patient requested assistance obtaining placement in an assisted living facility. During this visit, a primary care nurse completed a Columbia-Suicide Severity Rating Scale (C-SSRS) that was negative but included affirmative answers to thoughts of suicide.[14] A primary care physician evaluated the patient and ordered three consults: a nursing home consult that was canceled due to ineligibility two days after the primary care visit, an advance directive consult that was completed one week after the primary care visit, and a housing assistance consult that was completed 18 days after the primary care visit. A primary care social worker, who completed the housing assistance consult, documented contact with the patient twice in late spring 2023, and that assistance with the process of gaining aid and attendance was provided.[15]

In late spring 2023, Patient A called the VCL and expressed a need for help finding housing. A VCL responder's risk assessment indicated that the patient reported current suicidal thoughts,

[13] The OIG uses the singular form of they, "their" in this instance, for privacy purposes.

[14] The C-SSRS is VHA's screening tool for suicide risk, which "includes specific questioning about suicidal ideation, planning, and intent, and a history of suicidal behaviors." VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide."

[15] Aid and attendance is a monthly monetary benefit for veterans who receive a VA pension and meet eligibility criteria, which includes requiring help for routine personal care needs. "Geriatrics and Extended Care – VA Financial Benefits," VA, accessed October 16, 2023, www.va.gov/geriatrics/pages/VA_Financial_Benefits.asp; VA compensation and pension, including aid and attendance, may be used to help pay for needed services such as long term care. "Geriatrics and Extended Care – VA Financial Benefits," VA, accessed October 16, 2023, www.va.gov/geriatrics/pages/community_residential_care.asp.

which had occurred off and on for about a month, and admitted to having a plan for suicide as well as having a loaded gun in the home. The VCL responder assessed the patient as a moderate to low risk for suicide, asked the patient to consider unloading the gun, and completed a safety plan that included watching TV and playing solitaire to keep safe while awaiting services. The VCL responder also sent a VCL request to the facility suicide prevention team, noting the patient's preference related to privacy for any follow-up telephone calls.

Four days later, a suicide prevention staff member completed the VCL request noting a successful attempt in reaching the patient and the patient's spouse and that social work services would be requested to assist with the patient's request for alternative living arrangements. The suicide prevention staff member further documented "[r]isk assessed," however, failed to reference the results of the assessment, including whether the patient was experiencing suicidal ideation or had access to lethal means. Less than a week later, a different social worker documented a call made to the patient to further assist with housing and noted that the patient's spouse answered and stated an inability to talk because of an emergency in the home and the need to call 911. The social worker initiated a welfare check and the dispatcher who responded to the call informed the social worker that the patient had completed suicide by firearm.

Patient B

Patient B was a patient in their 60s with a psychiatric history significant for depression and substance use disorder and multiple medical comorbidities, including hypertension, hyperlipidemia, atrial fibrillation, and congestive heart failure. The patient called the VCL on a morning in early spring 2023, reporting depression and suicidal ideation with a plan to overdose on medication.[16] Later that day, the patient attempted suicide via overdose of blood pressure medication and acetaminophen.

Following the attempt, the patient was brought via ambulance to the facility where emergency department staff evaluated and treated the patient with measures to minimize impact from the overdose. Clinicians then facilitated the patient's admission to the intensive care unit (ICU) under a physician's emergency certificate.[17] During the hospitalization, the patient's course of treatment was complicated by a perforated intraabdominal abscess that required surgery.[18] While

[16] A VCL responder sent a referral for the patient to the facility suicide prevention team, however, the patient had been admitted to the facility at the time of the suicide prevention staff member's first VCL request response attempt the following day.

[17] An emergency certificate is legal authority for a treatment facility to detain a patient for diagnosis and treatment for up to 15 days when it is determined that the patient, by reason of a mental illness or substance related or addictive use disorder, is a danger to themselves or others or is gravely disabled and is unwilling to seek a voluntary admission. An initial physician's emergency certificate may be completed by a physician, nurse practitioner, physician assistant, or psychologist. La. Rev. Stat. Ann. § 28:53 (2023).

[18] A perforated intraabdominal abscess is a hole or rupture of a localized collection of pus within the patient's abdomen.

in the ICU, clinical staff documented continuous observation for reasons including suicide attempt by overdose or pulling out endotracheal tubes.[19]

Almost two weeks after admission, a psychiatric nurse practitioner noted the patient was too sedated to evaluate, completed a consultation for an expiring coroner's emergency certificate, and signed off from the patient's care.[20] The nurse practitioner advised that the treatment team could initiate a judicial commitment or allow Patient B's coroner's emergency certificate to expire and reassess at a later time.[21]

The following day, the patient attempted suicide twice by using medical equipment lines and a pillowcase, respectively. Facility clinicians reinitiated an order for one-to-one observation. One-to-one observation was continued when the patient was transferred from the ICU to a medical unit in mid-spring 2023, and was maintained through the rest of the patient's treatment until discharge to a community long term acute care facility four days later.[22]

During the patient's facility hospitalization, suicide prevention staff closed the VCL request and completed two suicide behavior reports and a high risk for suicide PRF placement. After discharge, suicide prevention staff documented two failed attempts to reach the patient in the month following discharge and approximately one month later, removed the high risk for suicide PRF, noting ongoing care in a community rehabilitation facility and "[a] chart review reveals no evidence of [suicidal ideation]."

[19] *Merriam-Webster.com Dictionary*, "endotracheal tube," accessed November 21, 2023, https://www.merriam-webster.com/dictionary/endotracheal%20tube#medicalDictionary. An endotracheal tube is a small tube inserted through the mouth or nose to deliver oxygen or medication to a patient's lungs.

[20] To continue involuntary treatment for up to 15 days after admission, a coroner or coroner's deputy must independently examine a patient and a coroner's emergency certificate must be completed within 72 hours of admission. La. Rev. Stat. Ann. § 28:53 (2023). In review of the EHR, the OIG found that a coroner's emergency certificate was completed for Patient B in early spring 2023. A psychiatrist documented that Patient B's certificate expired in an EHR note 16 days later. A new coroner's emergency certificate was completed two days later.

[21] A judicial commitment may be considered when a patient is a danger to themselves or others and requires continued involuntary medical treatment beyond the time frame allowed by a coroner's emergency certificate. La. Rev. Stat. Ann. § 28:53 (2023) and La. Rev. Stat. Ann. § 28:54 (2017).

[22] The patient was discharged from the community long term acute care facility to a community rehabilitation facility in early summer 2023. The patient was discharged from the community rehabilitation facility to home late summer 2023.

Inspection Results

1. Noncompliance with Suicide Prevention Policy and Guidance

The OIG substantiated that facility staff were not compliant with suicide prevention policy, finding noncompliance with several critical elements, including screening and assessment; documentation; staff oversight; and patient follow-up. Additionally, the OIG determined registered nurses had dual assignments and the facility's suicide prevention staffing was inadequate.

Failures in Suicide Risk Screening and Assessment

The OIG substantiated that clinical staff failed to follow suicide prevention policy for suicide risk screening and assessment. Specifically, a suicide prevention staff member did not screen or assess Patient A for suicide risk during a VCL request response call. The OIG also found that a suicide prevention staff member missed important information from Medora documentation when responding to Patient A's VCL request. Additionally, licensed independent providers (LIPs) did not complete a suicide risk assessment after Patient B's positive suicide risk screening in the Emergency Department.

In 2018, VHA implemented a process that requires standardized screening and assessment of suicide risk for all patients.[23] Clinical staff members complete screening as clinically indicated using the C-SSRS screening tool.[24] If patients have a positive screen, LIPs complete the Comprehensive Suicide Risk Evaluation (CSRE), which assesses risk and past history and informs LIPs on next steps to address patient needs.[25] The CSRE includes specific questions related to access to lethal means, such as guns, and identifies access to guns as a risk factor for suicide. Further, the CSRE assists an LIP in determining a patient's suicide risk level and risk

[23] VHA Suicide RISK ID Strategy, "Suicide Risk Identification."

[24] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to VISN Directors, VISN Chief Medical Officers, VISN Chief Mental Health Officers, Medical Center Directors, November 23, 2022. VHA policy states that, in addition to an annual requirement for suicide risk screening, "[t]here may be additional clinical situations, such as when a patient presents with a new behavioral health concern, when use of the C-SSRS and/or a CSRE is indicated."

[25] VA Suicide Risk Identification Strategy, "Staff Specific Guidance," March 22, 2023. For CSRE completion, VHA policy identifies an LIP as a medical doctor, doctor of osteopathic medicine, doctor of philosophy, doctor of psychology, clinical pharmacist practitioner, licensed clinical social worker or licensed master of social work or licensed independent social worker, licensed marriage and family therapist, licensed professional mental health counselor, advanced practice registered nurse, nurse practitioner, clinical nurse specialist, physician assistant, and rehabilitation counselor who "hold state licensure and are included in local bylaws as an independent practitioner."

mitigation actions, including welfare checks.[26] LIPs have up to 24 hours to complete a CSRE if it is "not logistically feasible or clinically appropriate" after positive C-SSRS in the emergency department and other inpatient settings.[27]

During facility VCL request response calls, VHA requires suicide prevention staff to reassess patients "for any potential risk," to include suicide.[28]

Although VHA policy does not explicitly state that Medora documentation must be reviewed, during interviews, the Facility Director and the suicide prevention program manager shared expectations that suicide prevention staff review Medora documentation prior to initiating VCL request response calls.

Patient A

In late spring 2023, a VCL responder documented in Medora that Patient A called the VCL and

- asked that the VCL request response call "only identify that the call is from the VA and not what department is contacting the veteran" if someone other than the patient answered the telephone;
- was "looking for assisted living;" and
- had a loaded gun in the home and "one" option was to "end [Patient A's] life."

Upon review of the patient's EHR, the OIG found that in response to the VCL request, the LIP suicide prevention staff member made two telephone contact attempts before speaking with Patient A and Patient A's spouse on the third attempt.

During an interview, when asked what the process is when preparing to contact a patient after a VCL call, the suicide prevention staff member stated preparation included reviewing Medora and the EHR. When asked if Patient A's information was reviewed, the suicide prevention staff member stated, "I did look at [Medora during the first call attempt] . . . .I did not review the [EHR]. The night that I made the final [third] call, I did not review." The suicide prevention staff member stated "unfortunately, I missed some crucial details." The suicide prevention staff member told the OIG that Patient A's spouse was on the third call and acknowledged being unaware of Patient A's request to not identify the caller's department at the time of the telephone

[26] VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide," December 2022. Welfare checks are completed when a patient is believed to be "a serious and imminent threat to the health and safety of an individual or the public."

[27] VA Suicide Risk Identification Strategy, "Minimum Requirements by Setting," May 10, 2023.

[28] VHA Directive 1503(2). VCL responders perform a standardized risk screening for patients who call the VCL by "addressing lethal means safety and developing individualized risk mitigations plans that contain a minimum of [three] components to address future risk."

call. The suicide prevention staff member denied having concerns "at the time" about Patient A's ability to freely answer questions while Patient A's spouse participated on the call.

When asked how suicide risk is assessed during a VCL request response call, the suicide prevention staff member reported,

> I think the best way to get an answer is to ask directly. We [do not] do [C-SSRSs] . . . on those calls . . . at least at this point we [do not]. I'm sure we will after today probably . . . I ask the question[s] directly. Are you thinking about killing yourself? Are you thinking about harming yourself?

The suicide prevention staff member told the OIG that Patient A was not asked about access to the gun during the call.

Following the call with Patient A and Patient A's spouse, the suicide prevention staff member documented that Patient A had "[r]isk assessed" during the call, however, there was no evidence of a risk assessment in the documentation. During an interview with the OIG, the suicide prevention staff member stated,

> I asked [Patient A], do you want to hurt yourself? Do you want to kill yourself? [Patient A] said 'no I want a place to live.' I [did not] ask [Patient A] did [Patient A] have a gun . . . . [M]y phone call . . . although [it is] not documented, was about 40 minutes. It was not a short phone call . . . there was no indication of suicidality.

During interviews with the OIG, the facility chief of Mental Health Service and a suicide prevention program manager stated an expectation that the suicide prevention staff member assess suicide risk during the VCL request response call.[29] The Facility Director stated that a suicide prevention staff member failing to review Medora documentation can result in missed information.

The OIG concluded that the suicide prevention staff member failed to act upon critical information Patient A provided to the VCL responder, which was documented in Medora, including the patient's access to lethal means and preference related to privacy. The OIG determined that, although clinically indicated, the suicide prevention staff member did not utilize the C-SSRS and CSRE to screen and assess Patient A's suicide risk.

Patient B

In early spring, Patient B called the VCL reporting depression and suicidal ideation with a plan to overdose on medication. Later that day, Patient B attempted suicide by overdose of two different medications and was taken by ambulance to the facility's Emergency Department. An

[29] The OIG learned during interviews that the suicide prevention program manager is the supervisor for the suicide prevention staff member.

emergency department nurse screened Patient B using the C-SSRS, and the screen was positive. The nurse documented a "hand off" to the emergency department physician. Patient B's medical condition in the Emergency Department necessitated an admission to the ICU later that night.[30]

Upon review of the patient's EHR, the OIG found that an LIP did not complete the required CSRE in either the Emergency Department or ICU. In an interview with the OIG, an ICU physician explained the clinical focus for Patient B was on medical stabilization. Further, the ICU physician reported a lack of awareness regarding the requirement to complete a CSRE after a positive C-SSRS and denied receiving education on completion of the CSRE. In an interview with the OIG, the Chief of Staff also stated that the clinical team was "focused on the medical issues."

The Chief of Staff described plans to work on changing the culture of the facility to "recognize our suicidal patients, just like we recognize medically sick patients." In an interview with the OIG, the Facility Director also noted the need for a cultural shift in mindset among staff related to suicide.

The OIG concluded that LIPs, in both the Emergency Department and ICU, failed to complete a CSRE after Patient B's positive suicide risk screen. The OIG acknowledges that the patient was likely unable to participate in a CSRE; therefore, the OIG did not make a recommendation for improvement.

Failure to Complete Dual Documentation for Veterans Crisis Line Calls

The OIG substantiated that a suicide prevention staff member did not document each contact attempt in response to Patient A's and Patient B's VCL requests in the EHR as required by VHA policy.[31]

VHA requires suicide prevention staff document each contact attempt in both Medora and the EHR (dual documentation).[32] VHA's Office of Mental Health and Suicide Prevention issued guidance to the field highlighting "Documenting attempts [only] in Medora creates a vulnerability where treatment teams are unable to see in the EHR that attempts are being made to contact Veterans" in response to a VCL call.[33] Once a suicide prevention staff member

[30] Patient B was admitted to the facility ICU with diagnoses of polypharmaceutical overdose and hypotension.

[31] VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide."

[32] VHA Directive 1503(2). VHA requires for "Customers [patients] with an electronic health record (EHR). . ." that a suicide prevention case manager ensure "each phone attempt. . . be documented in EHR . . . in addition to VCL web-based application [Medora]."

[33] VHA Office of Mental Health and Suicide Prevention, *Suicide Prevention Program VHA Directive 1503(2) Update*, December 2022.

completes the VCL request and documents follow-up information in Medora, the information from Medora is transferred to the EHR.[34]

Upon review of the patients' EHR, the OIG found that the suicide prevention staff member made two contact attempts prior to reaching Patient A with the third call and made three contact attempts to reach Patient B in response to VCL calls. In both cases, the suicide prevention staff member only documented in Medora.[35] The Medora documentation was not available in the EHR until the suicide prevention staff member completed the VCL requests, four days after Patient A's VCL call and seven days after Patient B's VCL call.

In interviews, the suicide prevention staff member reported awareness of the dual documentation requirement and when asked why there was not dual documentation of the outreach attempts, the suicide prevention staff member stated, "unfortunately, I just [did not] do it."

The OIG concluded that, although aware of the documentation requirement in response to VCL requests, a suicide prevention staff member failed to document each contact attempt in Patient A's and Patient B's EHRs. Failure to document contact attempts after patients call the VCL impedes transparent communication among healthcare providers and inhibits clinicians' ability to make informed patient-care decisions.

Failures in Performance Oversight and Clinical Case Reviews

The OIG substantiated that the suicide prevention program manager failed to take corrective action to address suicide prevention staff performance deficiencies identified during reviews of VCL request responses. Additionally, the suicide prevention program manager failed to complete and document required clinical case reviews for VCL request responses.

VHA directs facility managers to "complete regular performance reviews of . . . management of VCL [r]equests."[36] Further, VHA requires performance reviews include "[a] clinical case review of VCL [r]equest management electronic health record documentation."[37] Specifically, the clinical case review must include documentation as listed in VHA policy including assessment of patients for risk, actions taken to address issues in VCL request, and documentation of the VCL

[34] VA, "Veterans Crisis Line (VCL) Response Application User Guide," August 31, 2022.

[35] VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide." VHA requires VCL request response contact attempts to occur "within 1 business day of receipt" and "3 separate contact attempts on 3 separate days." The suicide prevention staff member made three contact attempts for Patient A and three contact attempts for Patient B.

[36] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Enhancing Management and Oversight of Veterans Crisis Line (VCL) Requests," memorandum to VISN Directors, VISN Chief Medical Officers and VISN Chief Mental Health Officers, March 15, 2023.

[37] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Enhancing Management and Oversight of Veterans Crisis Line (VCL) Requests," memorandum to VISN Directors, VISN Chief Medical Officers, and VISN Chief Mental Health Officers.

request response attempts in Medora and the EHR.[38] The OIG would expect that supervisors take, and document, corrective action when performance deficiencies are identified.

During an interview with the OIG, the suicide prevention program manager reported completing performance reviews of suicide prevention staff documentation of VCL request responses and verbalized some VCL request response elements to include when completing a VCL request. When asked if there were any concerns identified with the performance reviews, the suicide prevention program manager told the OIG that suicide prevention staff members were not addressing the problem of why a patient called the VCL and not completing dual documentation. When asked about corrective actions taken, the suicide prevention program manager acknowledged speaking with suicide prevention staff members but was unable to provide any documented evidence of the discussions or other corrective actions to address the identified VCL response deficiencies.

The OIG reviewed documentation of the suicide prevention program manager's completed performance reviews and found that not all clinical case review elements, as listed in VHA policy, were included in the manager's reviews.[39] The suicide prevention program manager conducted reviews of 18 VCL request responses and assessed elements such as whether consults were placed as requested by a patient and whether requests were closed within the required time frame. However, the manager's reviews did not include suicide prevention staff documentation of a patient's assessment of risk, "detailed information about what actions have been taken to resolve issues," or dual documentation.[40]

The OIG concluded that the suicide prevention program manager failed to address deficiencies with VCL request response documentation and failed to document conducting clinical case reviews as required by VHA policy. These oversight deficiencies increased the risk that patients' needs were not addressed.

Registered Nurse Dual Assignments

The OIG found that an ICU registered nurse served as Patient B's primary nurse and one-to-one observation staff member following Patient B's two inpatient suicide attempts. The OIG determined that when registered nurses function as both a patient's primary nurse and one-to-one observation staff member, patient care requirements impede the ability to constantly monitor the patient.[41]

[38] VHA Directive 1503(2).

[39] VHA Directive 1503(2).

[40] VHA Directive 1503(2).

[41] Through interviews with nursing staff, the OIG learned that additional nursing tasks may include review and documentation in the EHR, medication administration, or communicating with clinicians, staff, and others.

Facility policy states "[s]taff providing [one-to-one] observation should only be observing one patient at a time and have no other responsibilities during the assignment of [one-to-one] observation."[42] The Joint Commission National Patient Safety goal requires hospitals monitor for effectiveness of written policies in the management of suicidal patients.[43]

Upon review of the patient's EHR, the OIG found that an order for one-to-one observation was placed five minutes before Patient B's second inpatient suicide attempt.[44] Upon the OIG's physical inspection of the ICU, the OIG found that a registered nurse assigned to Patient B's room would be able to see the patient while documenting in the EHR outside the patient's room.

During interviews, ICU registered nurses and a nursing leader reported ICU registered nurses regularly act as both a registered nurse assigned to a patient and as the same patient's one-to-one observation staff member. At the time of Patient B's second inpatient suicide attempt, the registered nurse assigned to Patient B reported documenting in Patient B's EHR outside of the patient room and intervened immediately; no patient harm occurred.

The ICU registered nurse caring for Patient B reported serving as both the one-to-one observation staff member and the patient's assigned registered nurse after Patient B's inpatient suicide attempts and told the OIG that a dedicated one-to-one observation staff member was assigned the following morning. An ICU assistant nurse manager confirmed that a dedicated one-to-one observation staff member was assigned the morning after Patient B's inpatient suicide attempts.[45]

During interviews, the Chief of Staff and Associate Director for Patient Care Services told the OIG that facility staff were working to clarify facility procedures, including staff assignments, for one-to-one observation to address concerns that had been identified during a review of Patient B's care. On September 1, 2023, the Associate Director for Patient Care Services sent an email message to facility nurse leaders stating that a registered nurse assigned to observe a patient may not also be assigned as the patient's primary nurse. Further, the Associate Director for Patient Care Services provided the OIG with a revised standard operating procedure signed October 2, 2023, which clarified that a registered nurse observing the patient may not also be assigned as the patient's primary nurse.[46]

---

[42] Facility MCP 11-22, *Suicide Prevention Policy*, September 24, 2020.

[43] The Joint Commission E-dition, *National Patient Safety Goals*, 15.01.01.

[44] Additionally, Patient B's assigned nurse confirmed during an interview that there was no active one-to-one observation order during Patient B's first inpatient suicide attempt.

[45] The OIG reviewed documentation, including EHR nursing notes, electronic orders, observation flowsheets, and ICU staff assignment sheets, and asked during interviews but was unable to determine the exact time when a one-to-one observation staff member was assigned to the ICU following Patient B's second suicide attempt.

[46] Facility Standard Operating Procedure 118-61, *Telesitter Monitoring Close Observation and Continuous Observation*, September 1, 2023. Facility Standard Operating Procedure 118-61, *Telesitter Monitoring Close Observation and One to One Observation*, June 27, 2022.

The OIG concluded that Patient B's registered nurse had dual assignments as one-to-one observation staff member and primary nurse. As such, the facility staff failed to follow facility policy, which required that Patient B's one-to-one observation staff member have no other responsibilities. While the OIG noted the facility leaders had self-identified this concern and revised the policy to address the concern, in accordance with The Joint Commission, the OIG expects facility leaders monitor one-to-one observation staff member assignments to ensure policy compliance.

Failure to Ensure Mental Health Follow-up

The OIG substantiated that the facility failed to follow policy to ensure that Patient B had at least one mental health appointment monthly after a high risk for suicide PRF placement.[47] Further, facility staff interviewed by the OIG lacked consensus on who was responsible for ensuring Patient B received mental health services until PRF inactivation.

Per VHA policy, the suicide prevention team, in conjunction with other facility healthcare professionals, ensures that patients with an active high risk for suicide PRF have at least one mental health appointment monthly until PRF inactivation.[48]

Upon review of the EHR, the OIG found that a suicide prevention staff member placed Patient B's high risk for suicide PRF in early spring 2023, following the inpatient suicide attempts. Patient B was seen by a mental health physician assistant six days prior to discharge from the facility to a community long term acute care facility. The mental health physician assistant documented a recommendation to consult outpatient mental health staff for counseling and medication management prior to the patient's discharge. The OIG did not see evidence of an outpatient mental health consult or additional mental health care for Patient B through late summer 2023, when the patient was readmitted to the facility.

Facility staff and leaders told the OIG about being uncertain of Patient B's continuity of mental health care with VA and had varying views on who was responsible to ensure Patient B received mental health care after discharge from the community long term acute care and rehabilitation facilities.

---

[47] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. VA medical centers use a PRF in a patient's EHR to communicate to all VA staff that a patient is high risk for suicide. This Directive was rescinded with the publication of VHA Directive 1166, *Patient Record Flags,* November 6, 2023. VHA Directive 1166 contains similar language regarding the high risk for suicide PRFs definition.

[48] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Update to High Risk for Suicide Patient Record Flag (HRS-PRF) Changes," memorandum, to Veterans Integrated Services Network (VISN) Directors, VISN CMOs, VISN Chief Mental Health Officers, October 5, 2021. Facility staff must provide patients with four mental health appointments within the first 30 days of flag placement. Patient B was admitted at the time of flag placement and a mental health physician assistant saw Patient B 24 days after the PRF was placed. This memorandum was rescinded with the publication of VHA Directive 1166, *Patient Record Flags,* November 6, 2023. VHA Directive 1166 contains similar language related to the requirement for mental health appointments.

The VISN chief mental health officer expressed concerns about the adequacy of mental health follow-up for Patient B at the time of discharge. The Facility Director, chief of Mental Health Service, and chief of Social Work Service also admitted concerns with the lack of documented mental health follow-up at Patient B's discharge.

While on-site, the OIG met with VISN and facility leaders and reported a patient safety concern regarding Patient B's lack of mental health follow-up. The VISN Director and Chief of Staff acknowledged mutual concern and established a plan to schedule Patient B's mental health appointments. Later that day, a facility quality, safety, value staff member informed the OIG of Patient B's admission to the facility for an unrelated concern. The next day, the facility informed the OIG that the suicide prevention program manager saw the patient and inpatient mental health consults were entered. Upon review of the EHR, Patient B was evaluated by mental health staff while admitted and also attended a mental health outpatient appointment one day following discharge.

The OIG concluded that facility staff failed to ensure that Patient B, who had an active high risk for suicide PRF, had a mental health appointment as required by VHA policy. Additionally, the OIG noted the facility staff and leaders interviewed were unclear about who had responsibility to ensure mental health follow-up for Patient B after discharge.

Failure to Involve Treatment Team in Patient Record Flag Review

The OIG substantiated the suicide prevention staff failed to follow local and national policy for inactivation of Patient B's high risk for suicide PRF.[49] The OIG found that a suicide prevention staff member placed Patient B's high risk for suicide PRF appropriately; however, suicide prevention staff did not consult with other treatment team members, such as the patient's providers, prior to inactivation of Patient B's PRF.[50] Since decisions to inactivate high risk for suicide PRFs can have clinical impacts to a patient in terms of frequency of care and contacts required, treatment team members with knowledge of the patient should inform the decision regarding the inactivation of a high risk for suicide PRF.

A high risk for suicide PRF communicates to VA staff a patient's high risk for suicide, which should be considered when making treatment and scheduling decisions.[51] Indicators that a patient

[49] Facility MCP 11-22. VHA Notice 2022-06, "Inactivation Process for Category I High Risk for Suicide Patient Record Flags," July 21, 2022. This Notice was rescinded with publication of VHA Directive 1166, *Patient Record Flags*, November 6, 2023. VHA Directive 1166 contains similar language related to the management of PRFs.

[50] VHA Directive 2008-036. This Directive was rescinded with publication of VHA Directive 1166. VHA Directive 1166 contains similar language regarding suicide prevention coordinator responsibilities. Suicide prevention coordinators are responsible for maintaining high risk for suicide PRFs.

[51] VHA Directive 1166. VHA Directive 2008-036 was rescinded with publication of VHA Directive 1166. VHA Directive 2008-036 contains similar language regarding the purpose of high risk for suicide PRFs.

may be at high risk for suicide include a verified suicide attempt and seeking access to lethal means such as pills or weapons.[52]

Local facility policy states "[t]he decision regarding the activation, continuation, and inactivation of the [high risk for suicide] PRF is done in conjunction with the Suicide Prevention Team, Veteran and/or family members, and the Veteran's treatment team."[53] Further, national policy requires that suicide prevention coordinators include clinical care providers in high risk for suicide PRF management.[54]

Upon review of the patient's EHR, the OIG found that a suicide prevention staff member placed Patient B's high risk for suicide PRF after Patient B's two inpatient suicide attempts. Another suicide prevention staff member removed Patient B's PRF 82 days later without documentation of consultation with other treatment team members, such as the patient's providers or the community long term acute care facility the patient was discharged to, or the patient.[55]

During interview and email correspondence, the suicide prevention program manager told the OIG that no provider was consulted prior to Patient B's high risk for suicide PRF removal. The suicide prevention program manager recalled conducting an EHR review with a suicide prevention staff member prior to inactivating Patient B's PRF, and considering instances that drove the placement of the flag such as two inpatient suicide attempts. The suicide prevention program manager stated "[the suicide prevention team] attempted to reach [Patient B]" and that "I did not reach out to the [community long term care acute facility] staff." When asked by the OIG how the suicide prevention team determined that there was a reduction in clinical risk, the suicide prevention program manager stated that upon review of the EHR "I did not see anything in [patient B's EHR] . . . to tell me otherwise."

During an interview, the VISN chief mental health officer told the OIG that the VISN suicide prevention program manager identified concerns with the facility's process for high risk for suicide PRF inactivation and noted that that facility's high risk for suicide PRF inactivation process was "not as multidisciplinary as most facilities" and that inactivation of PRFs appeared to be based upon "[suicide prevention team] unilateral decisions." Per the VISN chief mental health officer, inactivation of a high risk for suicide PRF too early may reduce a patient's

[52] VHA Directive 2008-036. This Directive was rescinded with publication of VHA Directive 1166. VHA Directive 1166 contains similar language regarding indicators or features of high acute risk for suicide.

[53] Facility MCP 11-22.

[54] VHA Notice 2022-06. This Notice was rescinded with publication of VHA Directive 1166, *Patient Record Flags*, November 6, 2023. VHA Directive 1166 contains similar language that suicide prevention coordinators work collaboratively with entities including clinical care providers in the management of PRFs.

[55] The suicide prevention staff member attempted to call Patient B twice in midyear 2023 but both calls went to voicemail. The suicide prevention program manager was the only staff member listed as consulted for the high risk for suicide PRF inactivation note in Patient B's EHR.

visibility to providers. Thus, group input from a team-based approach on whether to discontinue a high risk for suicide PRF is a "wise practice."

The suicide prevention program manager admitted awareness that the process for review of the high risk for suicide PRF is supposed to include a patient's clinical care providers and reported stressing care providers' involvement in the process with the suicide prevention team. The suicide prevention program manager also acknowledged that the facility lacked a process for documentation of high risk for suicide PRF reviews with providers for decisions on inactivation of PRFs. When asked to explain the lack of provider input for Patient B's suicide PRF inactivation, the suicide prevention program manager told the OIG there was no provider input but did not explain why.

The OIG concluded that suicide prevention staff did not consult with Patient B's treatment team prior to inactivating the high risk for suicide PRF. Lack of input from the treatment team involved in patients' care may lead to inappropriate PRF inactivation for patients at high risk for suicide.

Delay in Completing the Behavioral Health Autopsy Program

The OIG substantiated that a suicide prevention staff member did not complete the BHAP chart review and the family interview contact form (FIT-C) timely following Patient A's death by suicide.[56]

The BHAP chart review is "[a] comprehensive review of a [patient's] EHR to identify contributory factors to suicide."[57] The BHAP family interview is completed to understand the circumstances impacting a veteran's life prior to death by suicide.[58] Both BHAP processes collect "information related to all [patient] deaths by suicide reported to VA facilities[59].

VHA policy requires that suicide prevention staff, within 30 days of becoming aware of a veteran suicide, complete the BHAP chart review, contact the next of kin, and complete the FIT-C Form.[60]

The BHAP chart review for Patient A was completed 66 days after the suicide prevention team was aware of the patient's death by suicide. The suicide prevention staff member documented telephone contact with Patient A's spouse in the EHR 70 days after Patient A's death by suicide.

[56] VHA Directive 1160.07.

[57] VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide." A suicide prevention staff member's role in this process is to inquire with family members their interest in speaking to the BHAP team and to complete the FIT-C Form, which includes the family members' contact information.

[58] VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide."

[59] VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide."

[60] VHA Directive 1160.07; VHA Office of Mental Health and Suicide Prevention, "Suicide Prevention Program Guide."

During an interview with the OIG, the suicide prevention staff member reported calling Patient A's spouse within a week and a half of the patient's passing but not documenting the contact in the patient's EHR.

During interviews with the OIG, the suicide prevention staff member identified contributing factors such as workload demands and work prioritization as reasons for the lack of timely documentation for Patient A. The suicide prevention staff member stated:

> We have . . . patients that we [cannot] even talk to that are in trouble. So, in prioritizing [what is] more important, you [cannot] save somebody that's already gone. So, I put the energy and effort into trying to work with the patients that are in trouble that I can have some degree of influence.

The OIG concluded that the facility was not in compliance with VHA BHAP timeliness requirements following Patient A's death by suicide. Delays in completing BHAP components, such as chart reviews and FIT-Cs, hinders the collection and application of lessons learned from veteran suicides to assist other veterans.

Inadequate Suicide Prevention Staffing

While on-site, the team identified an additional concern that the suicide prevention team staffing levels impeded the ability of the suicide prevention team to fulfill the requirements of VHA suicide prevention policy and guidance.[61] While facility and VISN leaders recognized the need for more suicide prevention staff, the OIG learned of delays with posting and difficulty in recruiting for vacant suicide prevention positions.

Facility directors are responsible for "[p]roviding the VA medical facility Suicide Prevention Program with sufficient resources to implement [the Suicide Prevention Program] directive."[62] At a minimum, each medical facility must maintain one suicide prevention coordinator "with a full-time commitment to the Suicide Prevention Program" but facility directors may appoint additional suicide prevention staff to support implementation of the directive. [63] Further, according to an August 2023 VHA memorandum, VISNs are expected to "encourage hiring of additional staff to support their suicide prevention teams" using a workload-based staffing model

[61] Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum; VHA Directive 1503(2); VHA Directive 1160.07.

[62] VHA Directive 1160.07.

[63] VHA Directive 1160.07. The Directive states that providing the suicide prevention program with sufficient resources may include "appointing more than one [suicide prevention coordinator] . . . or providing program support assistants."

from the Office of Mental Health and Suicide Prevention.[64] The VISN Suicide Prevention Program manager provided the OIG with a copy of the workload-based staffing model released in May 2023 for the facility Suicide Prevention Program, which indicated a need for 3.87 full-time equivalent suicide prevention coordinators, not including the suicide prevention program manager.

At the time of this inspection, the facility Suicide Prevention Program had three clinical staff members, including the program manager.[65] The chief of Mental Health Service told the OIG that the Suicide Prevention Program has had a vacancy since August 2022 for a suicide prevention case manager, which had been previously announced twice with no viable candidates.[66] In an email, the mental health operations manager told the OIG that the position was later filled in early fall 2023. The OIG also learned through interviews and document reviews that the Facility Director approved hiring four additional full-time suicide prevention coordinators in August 2023, following instruction from the VISN. As of November 20, 2023, those positions had not posted as human resources staff had not completed the announcements.

During interviews with the OIG, members of the suicide prevention team and VISN and facility leaders reported concerns with insufficient suicide prevention staffing and the impact of insufficient staffing on the facility's ability to meet Suicide Prevention Program requirements. The chief of Mental Health Service stated, "I think [it is] very difficult for people to give their very best every day if they [are] . . . fatigued." In an interview, a suicide prevention staff member stated,

> We have three staff. And we have so many patients and we have so many things to do, that it is a problem . . . . This job is exhausting . . . . It's mentally exhausting . . . . We need help.

Another suicide prevention staff member cited short staffing as a reason for not consistently completing duplicate documentation in the EHR and Medora stating "we are extremely short staffed. [We are] supposed to have seven people. [There is] not really a lot of time to be doing a lot of duplicate documentation."

The OIG reviewed a December 2022 VISN Mental Health Service site visit report, which noted that "with increased [Suicide Prevention Program] staffing, the team will be better able to manage the daily demands of the program and [improve] processes which [has] been difficult with decreased staffing." In email correspondence to the OIG in October 2023, the VISN suicide

[64] VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "For Action: Guidance for Reporting and Monitoring of Suicide Prevention Program (SPP) Staffing," memorandum to VISN Directors, August 8, 2023. The VISN Suicide Prevention Program manager stated that current and projected workload contributed to the VISN Director instructing the facility to hire additional Suicide Prevention Program staff.

[65] The suicide prevention program manager entered the position in late year 2022.

[66] The chief of Mental Health Service told the OIG that the position was announced in August 2022 and December 2022.

prevention program manager confirmed that the VISN Director instructed the facility to hire additional suicide prevention coordinators in spring 2023.

In interviews, a VISN leader and facility leaders expressed concerns regarding delays in human resources' processing of recruitment requests and recruiting difficulties. The VISN chief mental health officer reported that human resources staff turnover and training and oversight of new human resources staff contributed to delays in posting positions. The facility mental health operations manager shared email communication with the OIG documenting that the Mental Health Service prioritized the suicide prevention coordinator vacancy for recruitment. In one email, a VISN human resources specialist acknowledged delays in recruitment requests due to "team re-organization and . . . the influx of recruitment assignments."

In an interview with the OIG, the facility chief of Mental Health Service shared actions taken to address difficulties with suicide prevention staff recruitment, including pursuing direct hires and offering recruitment incentives such as compressed work schedules and financial incentives. Further, the facility chief of Mental Health Service reported conducting a pay analysis for social workers, conducting on-site recruitment events, and recruiting at college campuses.[67]

The OIG recognized that facility and VISN leaders identified and addressed insufficient suicide prevention staffing, however, the OIG identified a delay in posting suicide prevention coordinator positions approved in August 2023. Insufficient facility suicide prevention staffing limits the facility's ability to care for veterans at risk of suicide in accordance with VHA policy and guidance.

2. Request for Assisted Living

The OIG did not substantiate that the facility failed to act on Patient A's request for assisted living after the patient's primary care provider entered a community care nursing home consult and a social work service consult to help the patient with placement. The OIG found that a primary care social worker completed the consult within time frames required by VHA policy.

VHA policy states that "[t]he [c]onsult [r]eceiving [s]ervice is responsible for ensuring . . . timely review and response to consult requests."[68] The directive requires compliance with the *Consult Timeliness Standard Operating Procedure,* which states consults should be completed within 90 days of the patient indicated date.[69]

[67] The facility chief of Mental Health Service shared that the four suicide prevention coordinator positions are for social workers.

[68] VHA Directive 1232(5), *Consult Processes and Procedures*, August 24, 2016, amended December 5, 2022.

[69] VHA Directive 1232(5); VHA Office of Integrated Veteran Care, *Consult Timeliness Standard Operating Procedure (SOP*), last updated December 1, 2022; VHA Directive 1230, *Outpatient Scheduling Management*, June 1, 2022. The patient indicated date is the clinically indicated date agreed upon by the healthcare provider and the patient.

Upon review of the patient's EHR, the OIG found that Patient A's primary care provider entered a social work service consult to facilitate "seeking placement or other VA services" in mid-spring 2023. In late spring 2023, Patient A called a primary care social worker. During an interview, the social worker told the OIG of providing education to Patient A regarding ineligibility for contract nursing home placement and reported offering aid and attendance as an option to help pay for assisted living. The primary care social worker documented in late spring, that Patient A expressed interest in aid and attendance. Three days later, the primary care social worker documented calling the patient to provide an update that Patient A's primary care provider would complete the aid and attendance form. The primary care social worker completed the consult 18 days after the consult was entered.

The OIG concluded that the primary care social worker completed the consult within the time frame required by VHA policy. While Patient A was ineligible for VA contract nursing home care, the OIG found that the primary care social worker provided Patient A education on aid and attendance and coordinated with the patient's primary care provider. Ultimately, the primary care social worker addressed the patient's questions about assisted living and initiated the process for aid and attendance to help address the patient's needs.

Conclusion

The OIG substantiated that facility staff failed to comply with VHA suicide prevention policy requirements including

- completion of Patient A's suicide risk screening;
- completion of Patient A's and Patient B's suicide risk assessment;
- documentation of response to VCL requests in Patient A's and Patient B's EHRs;
- ensuring that Patient B had a mental health appointment after a high risk for suicide PRF placement;
- inactivation of Patient B's high risk for suicide PRF; and
- completion of a BHAP chart review and FIT-C form following Patient A's death by suicide.

The OIG concluded that a suicide prevention staff member did not screen or assess Patient A for suicide risk using the C-SSRS and CSRE and failed to act upon critical information Patient A provided to the VCL responder, which was documented in Medora.

Additionally, LIPs did not complete a suicide risk assessment after Patient B's positive suicide risk screening in the Emergency Department. However, the OIG acknowledges that the patient was likely unable to participate in a CSRE; therefore, the OIG did not make a recommendation for improvement.

Though aware of the dual documentation requirement in response to VCL requests, the suicide prevention staff member failed to document each contact attempt in Patient A's and Patient B's EHRs. Additionally, the suicide prevention program manager failed to take corrective action to address deficiencies identified during reviews of VCL request responses and failed to document conducting required clinical case reviews for VCL request responses.

The OIG concluded that facility staff failed to ensure that Patient B, who had an active high risk for suicide PRF, had a mental health appointment as required by VHA policy. The OIG noted that facility staff and leaders were unclear regarding who had responsibility to ensure mental health care for Patient B following discharge. Additionally, the suicide prevention team did not consult with Patient B's treatment team prior to inactivating the high risk for suicide PRF.

While on-site, the team identified two additional concerns. The first concern was that an ICU registered nurse served as both Patient B's primary nurse and one-to-one observation staff member following Patient B's two inpatient suicide attempts. As such, the facility failed to follow facility policy, which required Patient B's one-to-one observation staff member have no other responsibilities. While the OIG noted that facility staff had self-identified this concern and revised policy to address the concern, in accordance with The Joint Commission, the OIG expects facility leaders to monitor one-to-one observation staff member assignments for policy compliance.

The second concern was that the current suicide prevention team staffing levels impeded the ability of the suicide prevention team to fulfill the requirements of VHA suicide prevention policies. While facility and VISN leaders recognized the need for more suicide prevention staff, the OIG learned that there had been delays with posting of, and difficulty recruiting for, vacant suicide prevention positions that had been approved in August 2023.

The OIG did not substantiate that the facility failed to act on Patient A's request for assisted living after the patient's primary care provider entered a community care nursing home consult and a social work service consult to help the patient with placement. The OIG found that a primary care social worker completed the consult within time frames required by VHA policy.

Recommendations 1–8

1. The Overton Brooks VA Medical Center Director ensures the suicide prevention team utilizes information from Medora and the required Veterans Health Administration screening and evaluation tools when assessing patients' suicide risk in response to Veterans Crisis Line requests, and monitors for compliance.
2. The Overton Brooks VA Medical Center Director ensures the suicide prevention team follows national requirements for documenting each contact attempt in a patient's electronic health record when responding to Veterans Crisis Line requests, and monitors for compliance.

3. The Overton Brooks VA Medical Center Director ensures the suicide prevention program manager documents clinical case reviews of suicide prevention staff members' Veterans Crisis Line request responses and addresses identified deficiencies as required by the Veterans Health Administration.
4. The Overton Brooks VA Medical Center Director monitors intensive care unit one-to-one observation staff assignments for compliance with facility policy, and takes action as appropriate.
5. The Overton Brooks VA Medical Center Director ensures the provision of mental health appointments for patients with a high risk for suicide patient record flag as required by Veterans Health Administration policy, and monitors for compliance.
6. The Overton Brooks VA Medical Center Director ensures that suicide prevention staff consult with patients' treatment teams prior to inactivation of high risk for suicide patient record flags, and monitors for compliance.
7. The Overton Brooks VA Medical Center Director ensures timely completion of behavioral health autopsy program chart reviews and family interview contact forms, and monitors for compliance.
8. The Veterans Integrated Service Network Director takes steps to ensure that suicide prevention positions are posted and continues to identify additional recruitment opportunities for suicide prevention positions, as indicated.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 4, 2024

From: Director, South Central VA Health Care Network (10N16)

Subj: Healthcare Inspection—Noncompliance with Suicide Prevention Policies at the Overton Brooks VA Medical Center in Shreveport, LA

To: Director, Office of Healthcare Inspections (54HL09)
Director, GAO/OIG Accountability Liaison Office (VHA 10OICGOAL Action)

1. I have reviewed the draft report and concur with the response provided by the facility for the Noncompliance with Suicide Prevention Policies at the Overton Brooks VA Medical Center in Shreveport, LA, draft report.

2. I thank the Office of Inspector General for a thorough review of this case, and we will work closely with the Overton Brooks VA Medical Center on actions to improve compliance with Suicide Prevention Policies. If you have additional questions, please contact VISN 16 Quality Management Officer (QMO).

(*Original signed by:*)

Skye McDougall, Ph.D
South Central VA Health Care Network (VISN 16)

[**OIG comment**: The OIG received the above memorandum from VHA on June 7, 2024.]

VISN Director Response

Recommendation 8

The Veterans Integrated Service Network Director takes steps to ensure that suicide prevention positions are posted and continues to identify additional recruitment opportunities for suicide prevention positions, as indicated.

_X _Concur

____Nonconcur

Target date for completion: August 31, 2024

Director Comments

The VISN 16 Network Director and Deputy Human Resources Officer reviewed the recommendation and are committed to ensuring steps are taken to recruit and fill suicide prevention positions at the Overton Brooks VA Medical Center, Shreveport, Louisiana. Four suicide prevention coordinator (SPC) positions were previously posted, but recruitment was unsuccessful. Non-competitive selections have since been made for three of the four existing SPC positions and individuals are currently pending onboarding. The fourth position has been posted and is pending issuance of certificates to the selecting official.

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: April 5, 2024

From: Medical Center Director, Overton Brooks VA Medical Center (667)

Subj: Healthcare Inspection—Noncompliance with Suicide Prevention Policies at the Overton Brooks VA Medical Center in Shreveport, Louisiana

To: Director, South Central VA Health Care Network (10N16)

1. I have reviewed and concur with the Office of Inspector General report, Health Care Inspection – Noncompliance with Suicide Prevention Policies at the Overton Brooks VA Medical Center in Shreveport, LA.

2. I would like to thank the Office of Inspector General for their thorough review and their recommendations. Overton Brooks VA Medical Center is diligently working on action plans to improve our processes and we remain committed to providing quality care to our nation's Veterans

(*Original signed by*:)

Richard L. Crockett, MBA
Medical Center Director

[**OIG comment**: The OIG received the above memorandum from VHA on June 7, 2024.]

Facility Director Response

Recommendation 1

The Overton Brooks VA Medical Center Director ensures the suicide prevention team utilizes information from Medora and the required Veterans Health Administration screening and evaluation tools when assessing patients' suicide risk in response to Veterans Crisis Line requests and monitors for compliance.

_X _Concur

____Nonconcur

Target date for completion: August 31, 2024

Director Comments

The Medical Center Director and the Chief of Mental Health Service have reviewed the utilization of the required Veterans Health Administration screening and evaluation tools to determine compliance and concur with the recommendation. We will ensure the information from both Medora and the required Veterans Health Administration screening and evaluation tools are used by the suicide prevention team when assessing patients' suicide risk in response to Veterans Crisis Line requests.

A tracking tool will be utilized to monitor compliance to ensure information from Medora and the required Veterans Health Administration screening and evaluation tools are utilized when assessing patients' suicide risk in response to Veterans Crisis Line requests. We will establish a monitor with a benchmark of 90 percent and take additional corrective action as warranted**.**

Recommendation 2

The Overton Brooks VA Medical Center Director ensures the suicide prevention team follows national requirements for documenting each contact attempt in a patient's electronic health record when responding to Veterans Crisis Line requests and monitors for compliance.

_X _Concur

____Nonconcur

Target date for completion: August 31, 2024

Director Comments

The Medical Center Director and the Chief of Mental Health Service have reviewed the national requirements for documentation of contact attempts in the patient electronic health record and concur with the recommendation. We will ensure that the suicide prevention team adheres to

national requirements for the documentation of each contact attempt in the electronic health record when responding to [Veterans Crisis Line] VCL requests.

The Suicide Prevention Team will utilize a tracking tool to monitor compliance to ensure that each contact attempt in a patient's electronic health record is documented when responding to Veterans Crisis Line requests. We will establish a monitor with a benchmark of 90 percent. Additional corrective action will be taken if needed**.**

Recommendation 3

The Overton Brooks VA Medical Center Director ensures the suicide prevention program manager documents clinical case reviews of suicide prevention staff members' Veterans Crisis Line request responses and addresses identified deficiencies as required by the Veterans Health Administration.

_X _Concur

____Nonconcur

Target date for completion: August 31, 2024

Director Comments

The Medical Center Director and the Chief of Mental Health Service have reviewed and concur with this recommendation. The Chief of Mental Health Service will ensure that the suicide prevention program manager documents clinical case reviews of suicide prevention staff members' Veterans Crisis Line responses.

The Suicide Prevention Program Manager will utilize a tracking tool to conduct monthly clinical case reviews of Veteran Crisis Line requests and to monitor compliance. Data will be reported to Mental Health Executive Council monthly. A monitor with a benchmark of 90 percent will be established. Additional corrective action will be taken if warranted.

Recommendation 4

The Overton Brooks VA Medical Center Director monitors intensive care unit one-to-one observation staff assignments for compliance with facility policy and takes action as appropriate.

_X _Concur

____Nonconcur

Target date for completion: August 31, 2024

Director Comments

The Medical Center Director and the Associate Director of Patient Care Services have reviewed and concur with the recommendations for one-to-one staff assignments. Standard Operating Policy 118-61 'Telesitter Monitoring and Close Continuous Observation' was revised and signed on October 2, 2023. Education on this new Standard Operating Policy has been completed. All one-to-one assignments in the intensive care unit will be documented on a tracking form and reviewed to ensure compliance with this policy. A monitor will be established with a benchmark of 90 percent. Additional corrective action will be taken as warranted.

Recommendation 5

The Overton Brooks VA Medical Center Director ensures the provision of mental health appointments for patients with a high risk for suicide patient record flag as required by Veterans Health Administration policy and monitors for compliance.

_X _Concur

____Nonconcur

Target date for completion: August 31, 2024

Director Comments

The Medical Center Director and the Chief of Mental Health Service have reviewed and concur with the recommendation related to the provision of appointments for patients with a high risk of suicide. The Chief of Mental Health Service will ensure that patients who have a high risk for suicide patient flag have required mental health appointments, referred to as, "enhanced care visits," scheduled as required by policy.

Data will be tracked and measured monthly utilizing the High-Risk Flag Patient Tracking dashboard and will be reported to Mental Health Executive Council. Identified deficiencies will be addressed as needed. A benchmark of 90 percent will be established and additional corrective action will be taken as needed.

Recommendation 6

The Overton Brooks VA Medical Center Director ensures that suicide prevention staff consult with patients' treatment teams prior to inactivation of high risk for suicide patient record flags and monitors for compliance.

_X _Concur

____Nonconcur

Target date for completion: August 31, 2024

Director Comments

The Medical Center Director and the Chief of Mental Health Service recognize the importance of suicide prevention staff consulting with patients' treatment teams before inactivating a high risk for suicide patient flag. The Chief of Mental Health Service will make certain that suicide prevention staff consult with the patients' treatment teams prior to inactivation of these flags.

The High Risk for Suicide Patient Record Flag Clinical Review Team will conduct monthly meetings to review inactivation/continuation of High-Risk Flags. A tracking tool will be used to document the discussions. These reviews will be reported to Mental Health Executive Council monthly. A benchmark of 90 percent will be established and additional corrective action will be taken as needed.

Recommendation 7

The Overton Brooks VA Medical Center Director ensures timely completion of behavioral health autopsy program chart reviews and family interview contact forms and monitors for compliance.

_X _Concur

____Nonconcur

Target date for completion: May 21, 2024

Director Comments

The Medical Center Director, the Chief of Staff and the Chief of Mental Health Service have reviewed the requirements for the completion of behavioral health autopsy program chart reviews and family interview contact forms and concur with this recommendation. The Chief of Mental Health Service will ensure Behavioral Health Autopsy Program (BHAP) chart reviews and family interview contact forms (FIT-C) are completed as required. To ensure that all staff are aware of documentation standards, Suicide Prevention staff completed training on required documentation 'post completed suicide' on May 21, 2024. Any newly hired Suicide Prevention staff will complete 'post completed suicide' required documentation training during their orientation to the service. This training will be required and completed annually for all Suicide Prevention staff. Suicide Prevention staff will also monitor the BHAP Reconciliation Report monthly to ensure that all required suicide death reporting requirements are completed. We respectfully request closure of this recommendation.

OIG Comments

The OIG considers this recommendation open to allow for the submission of documentation to support closure.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection Team	Chris Iacovetti, BA, RD, Director Mark Bartuska, MHA, RN Margaret Fox, MS, RDN Jonathan Ginsberg, JD Meredith Magner-Perlin, MPH Vanessa Masullo, MD Ashley Summers, MJ, RN
Other Contributors	Shelby Assad, LCSW Lin Clegg, PhD Reynelda Garoutte, MHA, BSN Barbara Mallory-Sampat, JD, MSN Daphney Morris, MSN, RN Natalie Sadow, MBA Harold Stanek

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, South Central VA Health Care Network (10N16)
Director, Overton Brooks VA Medical Center (667/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Accountability
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
US Senate
  Arkansas: John Boozman, Tom Cotton
  Louisiana: Bill Cassidy, John Kennedy
  Texas: John Cornyn, Ted Cruz
US House of Representatives
  Arkansas: Bruce Westerman
  Louisiana: Troy Carter, Garret Graves, Clay Higgins, Mike Johnson, Julia Letlow, Steve Scalise
  Texas: Nathaniel Moran