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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Mental Health Emergency Response Documentation Inaccuracy, and Policy and Practice Inconsistencies at the VA San Diego Healthcare System in California

HEALTHCARE INSPECTION | REPORT #22-02188-109 | MAY 3, 2023

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Executive Summary

The VA Office of Inspector General (OIG) conducted an inspection to evaluate an allegation that staff at the San Diego VA Medical Center (facility) in California provided an inadequate evaluation of cognitive functioning, suicide risk, grave disability status, and care coordination for a patient who died approximately six hours after leaving the facility.[1] The OIG also evaluated a concern about inconsistencies between facility code green policy and practice.[2]

Synopsis of the Patient's Care

The patient, in their early 90's at the time of death, had a history of neurocognitive disorder, delusional disorder, and homelessness.[3] In early 2002, the patient was first evaluated at the facility for mental health care in the Psychiatric Emergency Clinic (PEC).[4] From 2002 through early 2022, the patient frequently presented to the PEC for unscheduled, same-day mental health care and did not consistently engage in routine outpatient mental health treatment despite several referrals.[5]

One day in late 2021, at approximately 4:15 a.m., a VA police officer (Officer 1) found the patient in the patient's car and informed the patient that sleeping in the car on facility grounds was not permissible. The patient reported "waiting to see [the patient's] primary care doctor" and "did not have any appointments." A check on the patient's registration indicated it was expired as of spring 2020. Officer 1 gave the patient "a verbal warning" regarding the registration. The patient denied needing to go to the Emergency Department and "proceeded to leave the parking structure."

One evening in early 2022, at approximately 9:00 p.m., Officer 1 and another VA police officer (Officer 2) responded to a report that the patient "was loitering in the hallway" near the Emergency Department. The patient denied needing assistance and described a plan to remain on VA property overnight and see a primary care provider the following morning. Officers 1 and 2 informed the patient that remaining on VA property overnight was considered loitering and not

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[1] "San Diego VA Medical Center to be Renamed," VA, accessed September 12, 2022, https://www.va.gov/san-diego-health-care/news-releases/san-diego-va-medical-center-to-be-renamed/. In March 2022, the San Diego VA Medical Center was renamed the Jennifer Moreno Department of Veterans Affairs Medical Center. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[2] Facility Memorandum 116A-06, "Code Green/Code Yellow," July 8, 2021. Facility policy defines a code green as "an emergency call requesting immediate Code Green Team intervention to manage disruptive and/or potentially dangerous behavior by a patient receiving care within the confines of the medical center buildings."

[3] The OIG uses the singular form of they (their) in this instance to preserve patient privacy.

[4] The PEC is a mental health triage clinic.

[5] From 2002 through early 2022, the patient presented to the facility's PEC 46 times and was referred for social work or mental health services 13 times.

allowed and suggested that the patient return the following day. The patient agreed to leave VA property and Officers 1 and 2 escorted the patient to the patient's vehicle. Officers 1 and 2 then determined that the patient did not have a license and the vehicle's registration was suspended. Officer 1 informed the patient that without a license or registration, the patient could not take the vehicle and that the vehicle would be towed. In response, the patient made statements referencing the use of lethal force, including "you should just shoot me," "shoot me right in my head," and "I will pretend I have a weapon to be shot." Officer 2 "became concerned for [the patient's] welfare," and escorted the patient to the Emergency Department "for a mental evaluation."

An Emergency Department triage nurse (triage nurse 1) called a code green and Officer 2 informed the code green team of "concerns of the [patient] losing [the patient's] vehicle." The code green team resident physician documented that the patient was "calm, linear, and coherent," denied medical concerns, and planned to return home.[6] The code green team resident physician also documented that the patient "adamantly denied suicidal ideation," and that the patient explained that earlier statements to Officers 1 and 2 were "said in jest." The resident physician determined that the patient did "not meet criteria for [a] psychiatric hold." Upon completion of the code green, the team leader documented, "passed care to [Emergency Department] triage." At 10:26 p.m., approximately an hour after the code green was called, Officer 2 provided the patient with transportation options including bus, trolley, or cab. The patient agreed to take the trolley and Officer 2 observed the patient enter the trolley station.[7]

At approximately 11:00 p.m., Officers 1 and 2 saw the patient at a bus stop on VA property and explained to the patient that buses were not in operation at that time and that the patient could not stay on VA property without a "valid reason" but could be treated in the Emergency Department. The patient agreed to go to the Emergency Department. Shortly after arrival, Emergency Department staff informed Officer 1 that the patient was loitering in the Emergency Department. Officer 1 informed the patient that sleeping in the waiting area was not allowed. The patient became upset and yelled, "I would like to kill 20 cops." Triage nurse 1 also told the OIG that the patient's threats to police "sounded like a general statement," and that "it didn't seem like there was substance to the threat." The patient refused to check-in to the Emergency Department and Officers 1 and 2 escorted the patient from the Emergency Department. Officer 1 told the patient

[6] Facility Memorandum 116A-06. The code green team included a resident physician; the team leader; three inpatient mental health unit nursing staff members, including a nurse supervisor; and Officers 1 and 2. The inpatient psychiatric nurse serves as the code green team leader and is responsible to direct the intervention, assure patient and staff safety, debrief the code green team, and complete a performance improvement monitor form. The team leader is also responsible for obtaining "a disposition decision" from the resident physician including if the patient meets criteria for a psychiatric hold.

[7] "Trolley System," San Diego Metropolitan Transit System, accessed September 7, 2022, https://www.sdmts.com/transit-services/trolley. The trolley is a "Light rail service that connects San Diego's Downtown with East County, UC San Diego, South Bay and the Mexico border" and includes a station at the facility.

the location to which the patient's vehicle was being towed and issued citations for disorderly conduct and loitering. At approximately 12:30 a.m., Officers 1 and 2 walked the patient off VA property and observed the patient continue walking until "out of sight."[8]

Approximately five hours later, San Diego Emergency Dispatch received a 911 call from a driver who reported having struck the patient on the interstate. The patient's death was reported to the Medical Examiner's Office less than 30 minutes later.

OIG Findings

The OIG did not substantiate that facility staff failed to adequately evaluate the patient's cognitive functioning, suicide risk, and grave disability. In interviews with the OIG, code green team and Emergency Department clinicians denied having concerns about the patient's cognitive functioning. The code green team leader documented that the patient was alert and oriented and told the OIG that the patient had a plan for where to stay. In an interview with the OIG, the code green team resident physician acknowledged not having formally assessed the patient's cognitive functioning and described the patient as having the ability to clearly communicate the decision to decline medical treatment and voice a future plan.

VA and Department of Defense Clinical Practice Guidelines instruct VA providers to ask patients who present with warning signs, such as suicidal ideation, directly about suicidal thoughts to identify suicide risk.[9] The code green team resident physician reported having asked the patient about suicidality and documented that the patient denied thoughts of harm to self or others.

Facility policy and California state law allow for a psychiatric hold if a patient is gravely disabled, defined as being unable to provide for "basic personal needs for food, clothing, or shelter" due to a mental health disorder.[10] The code green team resident physician told the OIG that the patient communicated a plan for self-care, including access to funds for food and a plan to purchase a trolley ticket home.[11] The code green team resident physician documented in the patient's electronic health record (EHR) that the patient did "not meet criteria for psychiatric hold" and told the OIG that the patient did not meet criteria for grave disability based on the patient's reported ability to provide and utilize food, clothing, and shelter. The OIG concluded

[8] The trolley runs from the VA Medical Center stop from approximately 5:00 a.m. until 12:30 a.m.

[9] VA/DOD, Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide, May 2019.

[10] Facility Memorandum 11-95, "Involuntary Detention at VA San Diego Healthcare System," November 17, 2018; Cal. Welfare & Institutions Code § 5008(h)(1)(A); § 5150(a); California Legislative Information, accessed April 26, 2022, https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5008 and https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5150.

[11] The patient's home address noted in the police report was an approximate one-hour trolley ride or 30-minute drive from the facility.

that the code green team resident physician assessed the patient and determined that the patient's mental health status did not interfere with the patient's ability to provide for basic personal needs.

The OIG substantiated that the code green team and Emergency Department staff failed to coordinate the patient's care as documented by the code green team leader. Although the code green team leader documented having "passed care" to Emergency Department staff, the OIG found that this transition of care did not occur. The code green team leader acknowledged in an interview with the OIG not speaking with anyone about the transition of care from the code green team and explained having the "understanding that the [Emergency Department] staff and VA Police would take care of the rest."

The patient denied medical or psychiatric concerns, refused Emergency Department services, was deemed to not meet criteria for a psychiatric hold and, therefore, had the right to decline care and leave the Emergency Department. The OIG concluded that the code green team leader inaccurately documented having "passed care" to Emergency Department staff. Although the inaccurate documentation did not appear to directly affect the management of the patient at the time, inaccurate documentation may contribute to misunderstandings regarding interventions provided to the patient.

Officer 2 reported to the OIG providing the patient "with the list of medical to social work" and the patient did not want "any assistance" and "just wanted to leave the Emergency Department." The OIG further concluded that when the patient later presented to the Emergency Department and refused all medical and social services offered, staff appropriately respected the patient's right to decline care.

During this inspection, the OIG found inconsistencies between facility policy and practice in the patient's code green event, including debriefing following the event, corrective action completion, and Code Green Committee responsibilities.[12] Additionally, the OIG found that the required performance improvement monitor form (code green monitor form) included roles not defined in facility policy.[13]

The OIG was unable to determine whether a code green team debriefing occurred after the patient's code green event, as required, because staff provided different reports.[14] Following the patient's code green event, the nurse supervisor documented a corrective action to "educate [the

[12] Facility Memorandum 116A-06. The debriefing is intended to identify injuries incurred, the reason for the disruptive behavior, successful aspects of the event, and any concerns. The code green monitor form includes a "Recommendations/Corrective action needed" section. The Code Green Committee, chaired by a mental health clinical nurse specialist or clinical nurse educator, is responsible to review code green events, analyze trends, and develop performance improvement plans.

[13] Facility Memorandum 116A-06.

[14] Facility Memorandum 116A-06.

VA Police Department] of reviewing code green criteria" on the code green monitor form. The nurse supervisor told the OIG about reminding Officers 1 and 2 of the criteria for calling a code green following the code green event. However, in interviews with the OIG, Officers 1 and 2 reported not receiving any additional education, and the VA police chief was unaware of the corrective action recommendation. The OIG concluded that education reportedly provided by the nurse supervisor to Officers 1 and 2 did not effectively resolve the corrective action documented in the code green monitor form. Failure of the Code Green Committee to ensure adequate resolution to identified corrective actions may result in repeated deficiencies in code green procedures and patient care.

In addition, facility policy does not identify required Code Green Committee membership and does not define the roles of "code supervisor" and "house supervisor," which are included in the code green monitor form.[15] The lack of defined Code Green Committee membership and code green team members' responsibilities may contribute to the Code Green Committee not providing sufficient oversight, and staff uncertainty of code green event expectations.

The OIG made two recommendations to the Facility Director related to confirming accuracy of code green documentation and evaluating facility code green policy to ensure compliance and alignment with procedures.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (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
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[15] Facility Memorandum 116A-06.

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Abbreviations

EHR	electronic health record
OIG	Office of Inspector General
PEC	Psychiatric Emergency Clinic
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted an inspection to evaluate an allegation that staff at the San Diego VA Medical Center (facility) in California provided inadequate evaluation of cognitive functioning, suicide risk, grave disability status, and care coordination for a patient who died approximately six hours after leaving the facility.[1] The OIG also evaluated a concern about inconsistencies between facility code green policy and practice.[2]

Background

The VA San Diego Healthcare System, part of Veterans Integrated Service Network (VISN) 22, provides healthcare services to more than 244,000 patients and includes the facility and seven community-based outpatient clinics.[3] The facility provides a range of services, including emergent, inpatient, long-term, and outpatient care. The VA San Diego Healthcare System is affiliated with the University of California, San Diego School of Medicine, and offers training to a number of clinical trainees, including over 1,200 medical interns, residents, and fellows.

Code Green

The Veterans Health Administration (VHA) does not require facility leaders to implement a behavioral health emergency response team.[4] Facility policy defines a code green as "an emergency call requesting immediate Code Green Team intervention to manage disruptive and/or potentially dangerous behavior by a patient receiving care within the confines of the medical center buildings."[5] The code green team includes an inpatient psychiatric nurse, a psychiatric resident (resident physician), and two or more VA police officers.[6] The inpatient psychiatric nurse serves as the code green team leader (team leader) and is responsible to direct the intervention, assure patient and staff safety, debrief the code green team, and complete a

[1] "San Diego VA Medical Center to be Renamed," VA, accessed September 12, 2022, https://www.va.gov/san-diego-health-care/news-releases/san-diego-va-medical-center-to-be-renamed/. In March 2022, the San Diego VA Medical Center was renamed the Jennifer Moreno Department of Veterans Affairs Medical Center. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

[2] Facility Memorandum 116A-06, "Code Green/Code Yellow," July 8, 2021.

[3] "Locations," VA San Diego Health Care, accessed April 29, 2022, https://www.va.gov/san-diego-health-care/locations/.

[4] "Behavioral Emergency Response Team vs Behavioral Rapid Response Team," VHA Prevention and Management of Disruptive Behavior.

[5] Facility Memorandum 116A-06.

[6] Facility Memorandum 116A-06.

performance improvement monitor form (code green monitor form).[7] The team leader is also responsible for obtaining "a disposition decision" from the resident physician including if the patient meets criteria for a psychiatric hold.[8]

The code green team debriefing is intended to identify injuries incurred, the reason for the disruptive behavior, and concerns related to the code green event.[9] The Code Green Committee, chaired by a mental health clinical nurse specialist or clinical nurse educator, is responsible to review code green events, analyze trends, and develop performance improvement plans.[10]

Grave Disability

California law states that an individual can be taken "into custody" for up to 72 hours (psychiatric hold) for assessment, treatment, and crisis intervention if determined to be gravely disabled. Grave disability is the condition of being unable to provide for "basic personal needs for food, clothing, or shelter" due to a mental health disorder.[11] California law advises the consideration of "available relevant information about the historical course" of the individual's mental health if it has a "reasonable bearing" on determining whether the individual is gravely disabled.[12] Historical information can be obtained from the individual's previous or current mental health provider, family members, and the individual or their designee.[13] Facility policy also states that a patient determined to be gravely disabled can be put on a psychiatric hold for "treatment and evaluation."[14]

Allegation and Related Concerns

On March 8, 2022, the OIG received an allegation that the patient died approximately six hours after facility staff provided inadequate evaluation of the patient's cognitive functioning, suicide risk, grave disability status, and care coordination.

During the evaluation of the allegation, the OIG identified an additional concern related to inconsistencies between facility code green policy and practice.[15]

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[7] Facility Memorandum 116A-06. *Merriam-Webster.com Dictionary,* "debrief," accessed September 15, 2022, https://www.merriam-webster.com/dictionary/debrief. To debrief is "to carefully review upon completion."

[8] Facility Memorandum 116A-06.

[9] Facility Memorandum 116A-06.

[10] Facility Memorandum 116A-06.

[11] Cal. Welfare & Institutions Code § 5008(h)(1)(A); California Legislative Information, accessed April 26, 2022, https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5008.

[12] Cal. Welfare & Institutions § 5150.05(a); California Public Law, accessed June 28, 2022, https://california.public.law/codes/ca_welf_and_inst_code_section_5150.05.

[13] Cal. Welfare & Institutions § 5150.05(b); California Public Law website.

[14] Facility Memorandum 11-95, "Involuntary Detention at VA San Diego Healthcare System," November 17, 2018.

[15] Facility Memorandum 116A-06.

Scope and Methodology

The OIG initiated the inspection on April 8, 2022, and conducted a virtual site visit from May 23–26, 2022.[16]

The OIG team interviewed the complainant, facility staff, and leaders knowledgeable about the patient's care or related procedures.

The OIG team reviewed relevant VHA and facility policies, facility organizational charts, and relevant California law related to grave disability. The OIG team also reviewed the patient's electronic health record (EHR), the medical examiner's report, VA police reports, facility internal reviews, and Code Green Committee meeting minutes.

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 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, Pub. L. No. 117-286, § 3(b), 136 Stat. 4196, 4206 (2022) (to be codified at 5 U.S.C. §§ 401–24). 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.

[16] The site visit was conducted virtually due to the Coronavirus (COVID-19) pandemic. "WHO Director-General's Opening Remarks at the Media Briefing on COVID-19 – 11 March 2020," World Health Organization, accessed July 7, 2022, https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---11-march-2020; *Merriam-Webster.com Dictionary,* "pandemic," accessed July 7, 2022, https://www.merriam-webster.com/dictionary/pandemic. A pandemic is "an outbreak of a disease that occurs over a wide geographic area…and typically affects a significant proportion of the population." "Naming the Coronavirus Disease (COVID-19) and the Virus that Causes It," World Health Organization, accessed July 7, 2022, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/naming-the-coronavirus-disease-(covid-2019)-and-the-virus-that-causes-it. COVID-19 is caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2).

Patient Case Summary

The patient received mental health care at 15 different VHA medical centers from 1989 until the patient's death in early 2022. The patient, in their early 90's at time of death, had a history of neurocognitive disorder, delusional disorder, and homelessness.[17] In early 2002, the patient was first evaluated for mental health care at the facility's Psychiatric Emergency Clinic (PEC).[18] A resident psychiatrist documented that the patient planned to sleep in a vehicle, was "clearly delusional," "obviously had these bizarre beliefs for many years and not gotten into trouble," and that the patient was not gravely disabled.

From 2002 through early 2022, the patient frequently presented to the PEC for unscheduled same-day mental health care and did not participate consistently in routine outpatient mental health treatment despite several referrals.[19] In late fall 2017, a PEC psychiatrist administered a cognitive impairment screening and diagnosed the patient with "mild dementia." Approximately three weeks later, a psychiatry resident physician determined the patient was gravely disabled and the patient was admitted to the inpatient mental health unit. At the time of discharge from the inpatient mental health unit, the discharging resident physician documented a diagnosis of "Neurocognitive disorder, mild-moderate."

From late summer through the end of 2021, the patient had one scheduled primary care appointment and received walk-in treatment and homeless program care management several times.[20] In late summer 2021, a primary care nurse determined the patient was "highly independent" to perform activities of daily living. On that same day, a primary care provider documented the patient reported not having a license and referred the patient to the PEC "for resources." Approximately 10 days later, the patient presented to the PEC and a social worker "discussed ways to get new [identification]" in response to the patient's report of a stolen wallet. The next day the patient presented to the Emergency Department requesting assistance with shelter and food after the patient's wallet was stolen. The patient reported "wanting to kill 10,000 people," denied a plan, and the Emergency Department physician documented that the patient stated having "general thoughts of hurting people and [the patient] has had these thoughts continously [*sic*] since [the patient] was in the service and these thoughts are unchanged. They are not directed at any specific person."

[17] The OIG uses the singular form of they (their) in this instance to preserve patient privacy.

[18] The PEC is a mental health triage clinic.

[19] From 2002 through early 2022, the patient presented to the facility's PEC 46 times and was referred for social work or mental health services 13 times.

[20] In late summer 2021, the patient presented for homeless program case management four times within two weeks when family asked the patient to leave the home. From late summer until the end of 2021, the patient presented for unscheduled treatment to primary care once, PEC once, and the Emergency Department six times.

While awaiting psychiatric evaluation, the patient attempted to leave the Emergency Department and a nurse called a code green. The code green team evaluated the patient, documented a history of neurocognitive disorder and delusions, noted that the patient was coherent, and determined that the patient did not meet criteria for a psychiatric hold. Approximately one week later, the patient told a homeless program social worker about being denied a driver's license by the Department of Motor Vehicles and not having identification. The social worker informed the patient of the process to obtain a senior identification and the patient was unwilling to follow through.

One day in late 2021, at approximately 4:15 a.m., a VA police officer (Officer 1) found the patient in the patient's car and informed the patient that sleeping in the car on facility grounds was not permissible. The patient reported "waiting to see [the patient's] primary care doctor" and "did not have any appointments." A check on the patient's registration indicated it was expired as of spring 2020 and the patient reported being "in the process of getting new registration, but it was proving difficult." Officer 1 and another VA police officer (Officer 2) advised the patient to "drive off property, but could return at 0600, and see the doctor, or" if in need of "immediate attention," to go to the Emergency Department. Officer 1 gave the patient "a verbal warning" regarding the registration. The patient denied needing to go to the Emergency Department and "proceeded to leave the parking structure."

Approximately three weeks later, a medical support assistant documented that the patient presented as a "walk in" and requested financial assistance. The patient met with a PEC nurse who noted that the patient exhibited paranoia and pressured speech, and did not understand that the PEC did "not help directly with financial problems." The PEC nurse documented a referral to social work. The patient next presented to the facility, about a week later, in early 2022 (see table 1 for sequence of events).

Table 1. Early 2022 Sequence of Events

Approximate Time	Patient Events
8:52 p.m.	• Officers 1 and 2 responded to a report that the patient "was loitering in the hallway" near the Emergency Department. • The patient denied needing assistance and described a plan to remain on VA property overnight and see a primary care provider the following morning. • Officers 1 and 2 informed the patient that remaining on VA property overnight was considered loitering and not allowed and suggested that the patient return the following day to see the primary care provider. • Officer 2 searched the patient and determined the patient did not have any weapons.
9:08 p.m.	• The patient agreed to leave VA property, and Officers 1 and 2 escorted the patient to the vehicle.

Approximate Time	Patient Events
	• Officer 2 asked the patient if registration was updated "since our last encounter with [the patient] a month prior," and the patient "stated it was stolen and may have been in the mail." • Officers 1 and 2 determined that the patient's vehicle's registration was suspended, and that the patient did not have a license. • Officer 2 informed the patient that without a license or registration, the patient could not take the vehicle and that the vehicle would be towed. • The patient made statements referencing the use of lethal force, including "you should just shoot me," "shoot me right in my head," and "I will pretend I have a weapon to be shot." • Officer 2 "became concerned for [the patient's] welfare," and escorted the patient to the Emergency Department "for a mental evaluation."
9:35 p.m.	• An Emergency Department triage nurse (triage nurse 1) called a code green. • Officer 2 informed the code green team of "concerns of [the patient] losing [the patient's] vehicle."[21]
10:09 p.m.	• The code green team resident physician documented that the patient o was "calm, linear, and coherent," o denied medical concerns, o "adamantly denied suicidal ideation," and thoughts of harming others, o stated that earlier statements to Officers 1 and 2 were "said in jest," o planned to return home, and o did "not meet criteria for psychiatric hold."
10:10 p.m.	• The team leader documented that the patient o "presented with disorganized thought process," o was alert and oriented, o made "vague statements" of suicidal ideation, and o planned to see the primary care provider the following morning. • Upon completion of the code green, the team leader documented, "passed care to [Emergency Department] triage."
10:26 p.m.	• Officer 2 provided the patient with transportation options including bus, trolley, and cab.[22] • The patient agreed to take the trolley and retrieved some belongings from the vehicle.

[21] The code green team included a resident physician; the team leader; three inpatient mental health unit nursing staff members, including a nurse supervisor; and Officers 1 and 2.

[22] "Trolley System," San Diego Metropolitan Transit System, accessed September 7, 2022, https://www.sdmts.com/transit-services/trolley. The trolley is a "Light rail service that connects San Diego's Downtown with East County, UC San Diego, South Bay and the Mexico border" and includes a station at the facility.

Approximate Time	Patient Events
	• Officer 2 escorted the patient to the trolley station and observed the patient enter the trolley station.
11:03 p.m.	• While on foot patrol, Officers 1 and 2 saw the patient at a bus stop on VA property. • Officers 1 and 2 explained that buses were not in operation at that time and that patient could not stay on VA property without a "valid reason" but could be treated in the Emergency Department. • The patient agreed to go to Emergency Department triage.
11:08 p.m.	• The patient walked into the Emergency Department triage area. • While Officer 1 conducted a check of the Emergency Department, staff informed Officer 1 that the patient was "believed to be loitering" in the Emergency Department. • The patient refused to check in to the Emergency Department.
11:15 p.m.	• Officers 1 and 2 escorted the patient from the Emergency Department. • Officer 2 observed the patient's car being towed and issued the patient citations for disorderly conduct and loitering. • Officer 1 informed the patient where the vehicle was taken.
12:35 a.m.	• Officers 1 and 2 walked the patient off facility property and observed the patient continue walking until "out of sight."[23]
5:54 a.m.	• Emergency Dispatch received a 911 call from a driver who reported having struck the patient who was between two lanes on the interstate.
6:16 a.m.	• The patient's death was reported to the Medical Examiner's Office.

Source: The patient's EHR, code green documentation, VA police, and Medical Examiner Office reports.

Inspection Results

1. Evaluation of Cognitive Functioning, Suicide Risk, and Grave Disability and Events Following the Code Green

The OIG did not substantiate that facility staff failed to adequately evaluate the patient's cognitive functioning, suicide risk, and grave disability. The OIG determined that Officers 1 and 2, the code green team, and triage nurse 1 did not have concerns about the patient's cognitive functioning. Further, the code green team resident physician noted that the patient "adamantly denied suicidal ideation" and determined that the patient did not meet criteria for psychiatric hold.

[23] The trolley runs at the VA Medical Center stop from approximately 5:00 a.m. until 12:30 a.m.

At approximately 9:15 p.m., Officer 2 escorted the patient to the Emergency Department after becoming "concerned for [the patient's] welfare" based on statements made by the patient such as "you should just shoot me," and "I will pretend I have a weapon to be shot."[24] At the request of Officer 2, triage nurse 1 called a code green. Triage nurse 1 reported to the OIG that Officers 1 and 2 did not communicate that the patient expressed suicidal ideation and requested a "psych evaluation" and a code green. Officer 2 documented informing the code green team of the patient's statements and "my concerns of [the patient] losing" the vehicle."

Cognitive Functioning

Although neurocognitive disorder may affect executive function, learning and memory, and social cognition, the OIG concluded that code green team and Emergency Department staff did not evaluate the patient's cognitive functioning because they did not identify concerns about cognitive impairment during their interaction with the patient.

In interviews with the OIG, code green team clinicians and Emergency Department staff denied having concerns about the patient's cognitive functioning. The code green team resident physician acknowledged not having formally assessed the patient's cognitive functioning and described the patient as having the ability to clearly communicate the decision to decline medical treatment and a future plan. The team leader documented that the patient demonstrated a "disorganized thought process" and told the OIG that evidence of disorganized thinking was based on the patient "joking around," and not wanting "to give us the answer" to the questions asked. The team leader also documented that the patient was alert and oriented and told the OIG that the patient was oriented and had a plan for where to stay. Additionally, triage nurse 1, who called the code green, told the OIG that the patient appeared "put together," was not frail or disheveled, and had no concerns about the patient's cognitive impairment.

Suicide Risk

VA and Department of Defense Clinical Practice Guidelines instruct VA providers to ask patients who present with warning signs such as suicidal ideation directly about suicidal thoughts to identify suicide risk.[25] If a patient does not screen positive for suicide risk, the provider is instructed to continue "routine management of care."[26]

Officers 1 and 2 escorted the patient to the Emergency Department and triage nurse 1 initiated the code green after the patient stated, "you should just shoot me," "shoot me right in my head,"

[24] The OIG estimated 9:15 p.m. as the time that Officer 2 escorted the patient to the Emergency Department based on facility documentation of events at 9:08 p.m. and 9:35 p.m.

[25] VA/DOD, *Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*, May 2019.

[26] VA/DOD, *Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*, May 2019.

and "I will pretend I have a weapon to be shot." The team leader told the OIG that the VA police communicated that the patient made suicidal statements and believed that the code green team resident physician assessed suicide risk. The code green team resident physician documented that the patient "adamantly denied suicidal ideation" and "thoughts to harm others." In an interview with the OIG, the code green team resident physician reported having asked the patient about suicidality and that the patient adamantly denied thoughts of harm to self or others. Further, the code green team resident physician reported that the patient denied medical and psychiatric concerns, declined Emergency Department evaluation, and verbalized a plan to return to the facility the next morning to visit the primary care physician.

Grave Disability

Facility policy and California state law allow for a psychiatric hold if a patient is a danger to self or others, or gravely disabled.[27] The associate chief of mental health told the OIG that the purpose of a code green is to de-escalate a crisis and determine if a patient meets criteria for a psychiatric hold and requires further evaluation.

The code green team resident physician told the OIG that the code green team is responsible to evaluate a patient for psychiatric hold. The code green team resident physician also noted that grave disability criteria includes an individual's inability to provide for food, clothing, or shelter due to a mental health disorder, and that the patient communicated a plan for self-care including access to funds for food, and a plan to purchase a trolley ticket home.[28] The code green team resident physician documented in the patient's EHR that the patient did "not meet criteria for psychiatric hold" and told the OIG that the patient did not meet criteria for grave disability based on the patient's reported ability to provide and utilize food, clothing, and shelter.

The section chief, acute mental health determined that the code green resident physician's evaluation was "an appropriate assessment in terms of the need to know whether the patient needed further evaluation and whether the patient was holdable." The section chief, acute mental health, told the OIG that the code green team resident physician "made a basic decision on the spot" about whether a psychiatric hold could be placed without time to review the patient's EHR. The code green team resident physician reported reviewing the patient's EHR after the evaluation and then documenting that the patient had a history of neurocognitive and delusional disorders.

Although the code green team resident physician did not include a review of the patient's EHR in determining whether the patient met criteria for grave disability, the OIG concluded that the code

[27] Facility Memorandum 11-95; Cal. Welfare & Institutions Code § 5150(a); California Legislative Information, accessed April 26, 2022, https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5150.

[28] The patient's home address noted in the police report was an approximate one-hour trolley ride and 30-minute drive from the facility.

green team resident physician assessed the patient and determined that the patient's mental health status did not interfere with the patient's ability to provide for basic personal needs, including food and shelter.

Events Following the Code Green

Approximately one hour after the patient's code green event, Officers 1 and 2 observed the patient on VA property and the patient described a plan to check into the Emergency Department. Officers 1 and 2 directed the patient to the Emergency Department.

The patient entered the Emergency Department; however, triage nurse 1 told Officers 1 and 2 that the patient did not check-in. Officer 1 encouraged the patient to check-in to the Emergency Department and the patient refused.

Officer 1 informed the patient that sleeping in the waiting area was not allowed, the patient became upset and yelled, "I would like to kill 20 cops." Triage nurse 1 also told the OIG that the patient's threats to police "sounded like a general statement," that "it didn't seem like there was substance to the threat," and the patient declined to check-in to the Emergency Department. Officer 2 told the OIG, "I went down the list of medical to social work" and the patient stated not wanting "any assistance" and "just wanted to leave the Emergency Department." Based on the patient's declination of medical care and social work assistance, and the code green team's earlier determination that the patient did not meet criteria for psychiatric hold, the OIG concluded that staff appropriately respected the patient's right to refuse care.

2. Inadequate Care Coordination

The OIG substantiated that the code green team and Emergency Department staff failed to coordinate the patient's care as documented by the code green team leader. Although the code green team leader documented having "passed care" to Emergency Department staff, the OIG found that this transition of care did not occur.

Officer 2 documented that after determining that the patient did not meet criteria for a psychiatric hold, the code green team "then departed from the [Emergency Department] and Nursing staff asked if they could further assist" the patient and the patient declined. Officer 2 documented explaining to the patient that the patient could not remain on facility property overnight and offered several transportation options. Upon Officer 2's offer of "any assistance," the patient stated "[the patient] would be ok and walked across the street from [the facility], where [the patient] entered the Trolley station platform."

Following the patient's code green event, the code green team leader documented the patient's plan to see the primary care provider the following day, that the code green ended, and "passed care" to the Emergency Department triage staff. In an interview with the OIG, the team leader acknowledged not speaking with anyone about the transition of care from the code green team

and explained having the "understanding once we ended our code green," that Emergency Department staff and the VA police "would take care of the rest."

The patient denied medical or psychiatric concerns, refused Emergency Department services, was deemed to not meet criteria for a psychiatric hold, and therefore, had the right to decline care and leave the Emergency Department. The OIG concluded that the team leader inaccurately documented having "passed care" to Emergency Department staff. Additionally, following the code green event, the VA police assisted the patient given the patient's right to decline care and leave the facility. Although the inaccurate documentation did not appear to directly affect the management of the patient at the time, inaccurate documentation may contribute to misunderstandings regarding intervention provided to the patient.

3. Code Green Policy and Practice Inconsistencies

The OIG found inconsistencies between facility policy and practice in the patient's code green event, including

- debriefing following the event,
- corrective action completion, and
- Code Green Committee responsibilities.[29]

Additionally, the OIG found that the code green monitor form included roles (code green team supervisor and house supervisor) not defined in facility policy.

Debriefing

The OIG was unable to determine whether a code green team debriefing occurred after the patient's code green event, as required, due to inconsistent information reported by facility staff.[30]

The team leader "debriefs the team at the conclusion of each code."[31] The debriefing is intended to identify injuries incurred, the reason for the disruptive behavior, successful aspects of the event, and any concerns.[32] Facility policy identifies optional steps in the management of the code green, including a

> huddle immediately following the Code Green event with all staff involved to address the motives for the behavior that led to the code, procedural aspects of the staff actions that

[29] Facility Memorandum 116A-06.

[30] Facility Memorandum 116A-06.

[31] Facility Memorandum 116A-06.

[32] Facility Memorandum 116A-06. The code green team nurse supervisor and a code green team nurse told the OIG that the debriefings are verbal huddles with participating staff and are not documented.

includes member and leader roles, safety of the patient, other patients, bystanders, and staff, timing and techniques employed, and suggestions for improvement.[33]

The team leader and Officer 2 told the OIG that a debrief did not occur. In interviews with the OIG, the code green team resident physician and a code green team nurse could not recall if a debriefing occurred. However, the nurse supervisor told the OIG that a debriefing occurred after the patient's code green concluded. The OIG would expect the team leader to conduct a team debrief as required and that all code green team members participate to ensure identified concerns are addressed. Failure to debrief with all code green team members may result in continued inefficiencies in the code green process.

Corrective Action Completion

The OIG concluded that the identified corrective action to provide VA police with education was not effectively resolved. The OIG would have expected the Code Green Committee to evaluate appropriate corrective action recommendations and ensure resolution.

The team leader is responsible to document the event on a code green monitor form "for data collection and analysis."[34] The code green monitor form includes a "Recommendations/Corrective action needed" section.

Officer 2 documented that after becoming concerned for the patient's safety, Officer 2 escorted the patient to the Emergency Department for a mental health evaluation. In an interview with the OIG, triage nurse 1 reported calling a code green after the patient refused to check-in to the Emergency Department.

Following the code green event, the nurse supervisor documented a corrective action to "Educate [the VA Police Department] of reviewing code green criteria." In an interview with the OIG, the nurse supervisor reported recommending this corrective action based on the understanding that the patient was not exhibiting non-compliant or irritable behavior. However, given the patient's concerning statements and declination to check-in to the Emergency Department, the OIG concluded that triage nurse 1 appropriately called the code green.

The nurse supervisor also told the OIG about reminding Officers 1 and 2 of the code green criteria following the Code Green event. In interviews with the OIG, Officers 1 and 2 reported not receiving any additional education and the VA police chief was unaware of the corrective action recommendation. The OIG concluded that any education the nurse supervisor provided did not effectively resolve the recommended corrective action.

Additionally, the OIG found that the Code Green Committee did not review the patient's code green event or evaluate the effectiveness and resolution of the identified corrective action. The

[33] Facility Memorandum 116A-06.

[34] Facility Memorandum 116A-06.

Code Green Committee co-chair reported to the OIG that the VA police were not informed of the recommended corrective action since a VA police representative did not attend the April, May, and June 2022 committee meetings, "but typically, this is something that would be brought up in the Code Green Committee meeting. Like if there was a VA Police representative there, we would provide education based on the, this feedback from this form."[35] Failure of the Code Green Committee to ensure adequate resolution to identified corrective actions may result in deficiencies in patient management and care.

Code Green Committee and Policy Definitions

The OIG found that the Code Green Committee did not review the patient's code green event as required. Further, the OIG found facility policy did not identify required Code Green Committee membership or roles identified on the code green monitor form.[36]

The Code Green Committee meets monthly and is responsible to review code green events, analyze trends, and develop performance improvement plans.[37] In addition, except for the Code Green Committee chair, facility policy does not identify required Code Green Committee membership.[38] Additionally, the code green monitor form included roles not defined in facility policy including "code supervisor" and "house supervisor."[39]

Consistent with the April 2022 Code Green Committee meeting minutes, the Code Green Committee co-chair told the OIG that the patient's code green event was not discussed. The OIG would expect all code green events to be discussed at Code Green Committee meetings as required so that appropriate actions are taken to address any issues identified from a code green event.[40] Further, the OIG would expect the code green policy to define Code Green Committee membership and Code Green Committee co-chairs responsibilities as well as code green team member roles that are included on the monitor form. The lack of defined Code Green Committee membership and code green team members' responsibilities may contribute to the Code Green Committee not providing sufficient oversight and staff uncertainty of code green event expectations.

[35] The Code Green Committee co-chair reported to the OIG that the April 2022 Code Green Committee meeting included information from code green events from January to March 2022, prior to returning to monthly meetings in May and June 2022.

[36] Facility Memorandum 116A-06.

[37] Facility Memorandum 116A-06.

[38] Facility Memorandum 116A-06.

[39] Facility Memorandum 116A-06.

[40] Facility Memorandum 116A-06.

Conclusion

The OIG did not substantiate that facility staff failed to adequately evaluate the patient's cognitive functioning, suicide risk, and grave disability. Although neurocognitive disorder may affect executive function, learning and memory, and social cognition, the code green team and Emergency Department staff did not evaluate the patient's cognitive functioning because they did not identify concerns about cognitive impairment during their interaction with the patient.

Consistent with VA and Department of Defense Clinical Practice Guidelines, the code green team resident physician reported in an interview with the OIG having asked the patient about suicidality and that the patient adamantly denied thoughts of harm to self or others.[41] Facility policy and California state law allow for a psychiatric hold if a patient is gravely disabled.[42] The code green team resident physician assessed the patient and determined that the patient's mental health status did not interfere with the patient's ability to provide for basic personal needs including food and shelter.

The code green team and Emergency Department staff failed to coordinate the patient's care as documented by the code green team leader. Although the code green team leader documented having "passed care" to Emergency Department staff, the OIG found that the team leader did not do so. The team leader's failure to accurately document the outcome of the code green event contributed to a misunderstanding of the patient's immediate disposition and the assistance offered to the patient.

The OIG found inconsistencies between facility policy and practice in the patient's code green event, including debriefing following the event, corrective action completion, and Code Green Committee responsibilities.[43] Additionally, the code green monitor form included roles not defined in facility policy.[44]

The OIG was unable to determine whether a code green team debriefing occurred after the patient's code green event, as required, due to inconsistent facility staff reports.[45] Although the nurse supervisor reported providing education to Officers 1 and 2, the OIG concluded that the

[41] VA/DOD, *Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide*, May 2019.

[42] Facility Memorandum 11-95; Cal. Welfare & Institutions Code § 5150(a); California Legislative Information, accessed April 26, 2022, https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5150.

[43] Facility Memorandum 116A-06. The debriefing is intended to identify injuries incurred, the reason for the disruptive behavior, successful aspects of the event, and any concerns. The code green monitor form includes a "Recommendations/Corrective action needed" section. The Code Green Committee, chaired by a mental health clinical nurse specialist or clinical nurse educator, is responsible to review code green events, analyze trends, and develop performance improvement plans.

[44] Facility Memorandum 116A-06.

[45] Facility Memorandum 116A-06.

corrective action to "Educate [the VA Police Department]" was not effectively resolved. The Code Green Committee did not review the patient's code green event or evaluate the effectiveness and resolution of the identified corrective action. Failure of the Code Green Committee to ensure adequate resolution to identified corrective actions may result in repeated deficiencies in patient management.

Facility policy did not identify required Code Green Committee membership and the code green monitor form included roles not defined in facility policy including "code supervisor" and "house supervisor."[46] The lack of defined Code Green Committee membership and code green team members' responsibilities may contribute to the Code Green Committee not providing sufficient oversight and staff uncertainty of code green event expectations.

Recommendations 1 and 2

1. The VA San Diego Healthcare System Director ensures the accuracy of code green documentation.
2. The VA San Diego Healthcare System Director evaluates the VA San Diego Healthcare System Memorandum 116A-06, "Code Green/Code Yellow," and aligns definitions, requirements, and responsibilities with purpose and practice, and monitors compliance.

[46] Facility Memorandum 116A-06.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 28, 2023

From: Network Director, VA Desert Pacific Healthcare Network (10N22)

Subj: Healthcare Inspection—Mental Health Emergency Response Documentation Inaccuracy, and Policy and Practice Inconsistencies at the VA San Diego Healthcare System in California

To: Director, Office of Healthcare Inspections (54MH01)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. Thank you for the opportunity to review and comment on the Office of Inspector General (OIG) report, Mental Health Emergency Response Documentation Inaccuracy, and Policy and Practice Inconsistencies at the VA San Diego Healthcare System in California.

2. Based on the thorough review of the report by VISN 22 Leadership, I concur with the recommendations and submitted actions plans of the VA San Diego Healthcare System.

3. If you have additional questions or need further information, please contact the VISN 22 Quality Management Officer.

(*Original signed by:*)

Michael W. Fisher
VISN 22 Network Director

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: March 22, 2023

From: Director, VA San Diego Healthcare System (664)

Subj: Healthcare Inspection—Mental Health Emergency Response Documentation Inaccuracy, and Policy and Practice Inconsistencies at the VA San Diego Healthcare System in California

To: Director, Desert Pacific Healthcare Network (10N22)

1. We appreciate the opportunity to review the draft report of the Mental Health Emergency Response Documentation Inaccuracy, and Policy and Practice Inconsistencies at the VA San Diego Healthcare System in California.
2. I have reviewed the recommendations and concur with the responses and actions provided by our team here at the VA San Diego Healthcare System to ensure we continue to deliver excellent care to our Veterans.

(*Original signed by*:)

Frank Pearson, DPT, PA-C
Director, VASDHS

Facility Director Response

Recommendation 1

The VA San Diego Healthcare System Director ensures the accuracy of code green documentation.

Concur.

Target date for completion: December 1, 2023

Director Comments

The Chair of the Code Green (Behavioral) Committee with Mental Health, Nursing, and Police Services reviewed the VA San Diego Healthcare System Code Green Team Leader documentation and determined that revisions to the Code Green Leader documentation were indicated. Revisions of the Code Green process improvement paper form and revisions to the Code Green Leader electronic note will be implemented in order to accurately reflect clinical care provided and to ensure safe transitions of care following Code Green events. The Code Green Committee Chair's quarterly report to the Leadership Board will include compliance with monitoring and an analysis and trending of data as well as performance and process improvement plans. Monitoring will continue until 90% compliance for 6 consecutive months is achieved.

Recommendation 2

The VA San Diego Healthcare System Director evaluates the VA San Diego Healthcare System Memorandum 116A-06, "Code Green/Code Yellow," and aligns definitions, requirements, and responsibilities with purpose and practice, and monitors compliance.

Concur.

Target date for completion: December 29, 2023

Director Comments

The Chair of the Code Green Committee with Mental Health, Nursing, and Police Services reviewed the VA San Diego Healthcare System Memorandum 116A-06, "Code Green/Code Yellow," and will update the policy to align with current practice ensuring clear definitions and delineation of responsibilities. Training will be provided on Memorandum 116A-06. The Police Service and the Code Green Committee Chair will report to the Leadership Board quarterly to include compliance with monitoring and an analysis and trending of data as well as performance and process improvement plans. Monitoring will continue until 90% compliance for 6 consecutive months is achieved.

Glossary

To go back, press "alt" and "left arrow" keys.

activities of daily living. Routine tasks to be performed independently including personal hygiene, eating, and moving from one position to another.[47]

delusional disorder. A disorder characterized by the presence of fixed false beliefs that is unrelated to another psychiatric disorder or medical cause.[48]

dementia. Cognitive decline, ranging from mild to severe, that affects an individual's daily functioning.[49]

grave disability. According to California law, the condition of being unable to provide for "basic personal needs for food, clothing, or shelter" due to a mental health disorder.[50]

neurocognitive disorder. A broad term to describe a group of disorders that have disturbances in cognition as a primary component.[51]

paranoia. A pattern of excessive or irrational mistrust and suspiciousness of others.[52]

[47] Centers for Medicare and Medicaid Services, "Activities of Daily Living (ADLs)," accessed September 6, 2022, https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/downloads/2008_Appendix_B.pdf#:~:text=Instrumental%20Activities%20of%20Daily%20Living%20are%20activities%20related,light%20or%20heavy%20housework%2C%20and%20using%20a%20telephone.

[48] Science Direct, "Delusional Disorder," accessed September 7, 2022, https://www.sciencedirect.com/topics/neuroscience/delusional-disorder.

[49] National Institute on Aging, "Basics of Alzheimer's Disease and Dementia: What is Dementia? Symptoms, Types, and Diagnosis," accessed September 7, 2022, https://www.nia.nih.gov/health/what-is-dementia#:~:text=Dementia%20is%20the%20loss%20of,and%20their%20personalities%20may%20change.

[50] Cal. Welfare & Institutions Code § 5008(h)(1)(A); California Legislative Information, accessed April 26, 2022, https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5008.

[51] American Psychiatric Association, "Neurocognitive Disorders," accessed September 6, 2022, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425787.x17_Neurocognitive_Disorders; Neurocognitive Research Institute, "Neurocognitive Disorder," accessed September 6, 2022, https://www.thencri.org/glossary/neurocognitive-disorder/.

[52] *Merriam-Webster.com Dictionary,* "paranoia," accessed September 7, 2022, https://www.merriam-webster.com/dictionary/paranoia.

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