DEPARTMENT OF VETERANS AFFAIRS

**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

# Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide

# Minneapolis VA Health Care System

# Minnesota

HEALTHCARE INSPECTION | REPORT #18-02875-305 | SEPTEMBER 25, 2018


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# Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of Representative Tim Walz regarding the care of a patient (Patient) who was admitted to the inpatient mental health (MH) unit at the Minneapolis VA Health Care System (System), Minnesota. The Patient died from a self-inflicted gunshot wound less than 24 hours after discharge.

Additionally, the OIG team reviewed System leaders' actions following the Patient's death.

The OIG team determined that inpatient MH staff failed to

- Include the Patient's outpatient treatment team in discharge planning,[1]
- Identify an outpatient prescriber and schedule an outpatient medication management follow-up appointment,
- Adequately document assessment of firearms access and educate the Patient on limiting access to firearms,[2] and
- Document the Patient's declination to engage family in treatment planning and discharge planning.[3]

Proper documentation is necessary for sound clinical decision making.[4] In addition to the two documentation omissions noted above, the OIG team identified that the Patient's electronic health record from this episode of care[5] contained inconsistent and contradictory documentation regarding the Patient's access to firearms or other lethal means.[6] Three of nine clinicians documented the Patient had access to firearms and four documented "no" or "unknown." One

[1] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013; Minneapolis VA HCS, Memorandum #204A, Admission & Discharge from Inpatient Psychiatry, July 7, 2017.

[2] VHA, Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version: August 20, 2008; VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 1.0.

[3] VA Deputy Undersecretary for Health for Operations and Management, Memorandum - Eliminating Veteran Suicide: Enhancing Inpatient Mental Health and Residential Rehabilitation Treatment Program (RRTP) Discharge Planning and Follow-up, June 12, 2017; Minneapolis VA HCS, Standard Operating Procedure: Inpatient Mental Health (1K) Discharge Planning and Follow-up, September 14, 2017.

[4] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[5] This episode of care began on Day 1 with a Veterans Crisis Line contact and ended on Day 4 when discharged from the MH inpatient unit.

[6] Although System clinicians documented different information from the Patient, the OIG team did not find evidence that the interdisciplinary treatment team reconciled the discrepancies.

clinician documented "not assessed" and the remaining entry stated that the Patient did not have a specific plan for suicide but documented "yes" to having "means to carry out the suicide plan."

The OIG team further determined that the System Suicide Prevention Coordinator did not

- Collaborate with the Patient's interdisciplinary treatment team during admission or participate in discharge planning,[7]
- Determine the need for a Patient Record Flag (high risk for suicide) prior to discharge, or[8]
- Provide Suicide Behavior Report training to System clinical staff.[9]

While the OIG identified these deficits in the care provided to the Patient, the OIG team was unable to determine that any one, or some combination, was a causal factor in the Patient's death.

The OIG team also found that the Suicide Prevention Coordinator did not submit Behavioral Health Autopsies within established Veterans Health Administration (VHA) timeframes. The OIG reviewed a sample of the System's 2017 and 2018 Behavioral Health Autopsies and found that the Suicide Prevention Coordinator failed to complete four of the 18 (22 percent) Behavioral Health Autopsies within the required 30 days following notification of the death.[10]

The OIG team reviewed a sample of monthly Suicide Awareness Prevention Committee meeting minutes for 2018 and found the minutes did not included documentation of action item due dates or evidence of follow-up, as required by the Committee policy.

The System completed a Root Cause Analysis (RCA) related to the Patient's death. The Patient Safety Manager improperly included two individuals on the RCA team who were directly involved in the subject event.[11] Additionally, the OIG found that the RCA team conducted only two interviews and failed to interview several clinicians with direct knowledge of the Patient 's inpatient and outpatient MH services. Further, the RCA team did not identify a root cause for the suicide.

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[7] Minneapolis VA HCS, Policy TX-18D Identification & Assessment of Patients with Suicide Ideation or Suicide Behavior, November 18, 2016; VHA Handbook 1160.06; VHA Directive 2008-036, Use of Patient Record Flags to Identify Patients at High Risk for Suicide, July 18, 2008.

[8] Minneapolis VA HCS, *Policy TX-18D;* Minneapolis VA HCS, *Documentation Guidelines MH* (n.d.).

[9] VA Deputy Under Secretary for Health Operations and Management. Memorandum - *High Risk for Suicide Patient Record Flag Changes*. October 3, 2017.

[10] VA Deputy Under Secretary for Health for Operations and Management, Memorandum - *Behavioral Autopsy Program Implementation,* December 11, 2012.

[11] VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. An RCA is a process used to identify "…the basic or contributing causal factors that underlie variations in performance associated with adverse events." The Handbook further states that "individuals directly involved in the adverse event or close call under review" should be excluded.

The OIG made seven recommendations related to (1) interdisciplinary team collaboration; (2) team composition for determining a "High Risk for Suicide" Patient Record Flag status; (3) accuracy of MH clinical documentation, including attempts to engage family in treatment and the issue of patient lethality; (4) clinician training for Suicide Behavior Reporting; (5) timely completion of Behavioral Health Autopsies; (6) documentation of Suicide Awareness Prevention Committee activities; and (7) the root cause analysis process.

## Comments

The Veterans Integrated Service Network and System Acting Directors concurred with Recommendations 1 and 3–7, concurred in principle with Recommendation 2, and provided acceptable action plans. (See Appendixes B–C, pages 29–33 for the comments.) The OIG considers all recommendations open and will follow up on the planned actions until they are completed.

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for Healthcare Inspections

# Contents

# Abbreviations

| | |
|---|---|
| APRN | Advanced Practice Registered Nurse |
| BHA | Behavioral Health Autopsy |
| ED | Emergency Department |
| EHR | electronic health record |
| FY | fiscal year |
| ITT | interdisciplinary treatment team |
| MH | mental health |
| MHTC | Mental Health Treatment Coordinator |
| OIG | Office of Inspector General |
| SPC | Suicide Prevention Coordinator |
| SPCM | Suicide Prevention Case Manager |
| TJC | The Joint Commission |
| TMS | Talent Management System |
| VCL | Veterans Crisis Line |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |

# Introduction

## Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of Representative Tim Walz regarding the care of a patient (Patient) who was admitted to the inpatient mental health (MH) unit at the Minneapolis VA Health Care System (System), Minnesota. The Patient died from a self-inflicted gunshot wound less than 24 hours after discharge.

## Background

The System, part of Veterans Integrated Service Network (VISN) 23, is composed of the main hospital located in Minneapolis, Minnesota, and 13 community clinics located in Minnesota and Wisconsin. The System's hospital is a complexity 1a facility that provides MH services as well as acute, primary, specialty, and long-term care.[12]

The Minnesota clinics are located in Hibbing, St. James, Mankato, Maplewood, Rochester, Ramsey, Albert Lea, Shakopee, and Ely; the Wisconsin clinics are located in Rice Lake, Hayward, Superior, and Chippewa Falls. In fiscal year 2017, the System served 102,758 patients with 309 beds in operation, including 229 inpatient beds and 80 community living center beds. The System is affiliated with 63 universities and colleges including the University of Minnesota Schools of Medicine and Dentistry.

### Veteran Suicide Rates

A Veterans Health Administration (VHA) review of 55 million veteran records covering the period from 1979–2014 found that in 2014, the number of veteran deaths by suicide averaged 20 per day.[13] In 2014, the annual rate of suicide among U.S. civilian adult males was 25 per

[12] The VHA Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Level designations are 1a, 1b, 1c, 2, or 3—with Level 1a facilities the most administratively complex and Level 3 facilities the least complex. See, VHA Office of Productivity, Efficiency and Staffing, http://opes.vssc.med.va.gov/FacilityComplexityLevels/Pages/default.aspx. (The website was accessed on May 17, 2018.)

[13] U.S. Department of Veterans Affairs Office of Suicide Prevention, *Suicide Among Veterans and Other Americans, 2001-2014,* August 3, 2016 (updated August 2017).

100,000. The rate of suicide among male veterans was 37.2 per 100,000.[14] The overall suicide rate for veterans is 35.6 per 100,000. Additionally, from 2001 to 2014, the suicide rate for veterans who did not access VHA services increased by 38.4 percent, while the overall rate for veterans who accessed VHA treatment increased by 5.4 percent.[15] While the suicide mortality rate associated with firearms is higher when compared to other methods, proportionally, the use of firearms in suicides is higher among both male and female veterans than among the adult civilian population.[16]

## Care Coordination

VHA patient care focuses on improved health care and patient safety by promoting collaboration among all healthcare professionals and treatment teams and ensuring communication when veterans transition to different levels of care.[17]

## Veterans Crisis Line

In July 2007, VA established the National Veterans Suicide Prevention Hotline, a telephone hotline for veterans, families of veterans, and military personnel. In 2011, the VA renamed the Hotline to Veterans Crisis Line (VCL), encouraging veterans and their friends and families to use the resource for emotional support and intervention, including when risk of suicide arises.[18] Since 2007, VCL staff answered more than 2.8 million calls and initiated the dispatch of emergency services to callers in crisis over 74,000 times. VA also implemented text and chat

[14] VA Office of Mental Health and Suicide Prevention. "Facts about Veteran Suicide*," August 2017.* https://www.mentalhealth.va.gov/docs/VA-Suicide-Prevention-Fact-Sheet.pdf. (The website was accessed on May 25, 2018.)

[15] Brenner Lisa A., Claire Hoffmire, Nathaniel Mohatt, Jeri E. Forster, "Preventing Suicide among Veterans Will Require Clinicians and Researchers to Adopt a Public Health Approach," *Forum - VHA Health Services Research & Development Service* (Spring 2018).

https://www.hsrd.research.va.gov/publications/forum/spring18/default.cfm?ForumMenu=Spring18-1. (The website was accessed on June 12, 2018.)

[16] VA Office of Mental Health and Suicide Prevention. *Suicide Among Veterans and Other Americans 2001–2014*.

[17] VHA, Office of Patient Care Services, "Coordinated Care-PACT." https://www.patientcare.va.gov/primarycare/pact/coordination.asp, September 15, 2016. (The website was accessed on June 29, 2018.)

[18] Suicidepreventionlifeline.org. "About the Veterans Crisis Line." 'https://www.veteranscrisisline.net/About/AboutVeteransCrisisLine.aspx, (n.d.). (The website was accessed on July 13, 2018.

services; VCL staff engaged in more than 332,000 online chats and responded to more than 67,000 texts.[19]

For veterans who call VCL and are at risk of self-harm, VCL call-responders submit a consult to alert a facility's Suicide Prevention Coordinator (SPC).[20] The SPC is responsible for responding to the consult and ensuring the veteran receives evaluation and treatment from appropriate VA or other healthcare services.[21]

## VHA Suicide Risk Assessment

VHA suicide risk assessment and prevention guidelines include standardized screening questions and an in-depth evaluation and assessment of suicide risk when screenings are positive.[22,23] VHA and System policies require that providers complete suicide risk assessments prior to and at the time of a patient's admission to an inpatient MH unit. Additionally, at discharge, the patient must be reevaluated for suicide risk and flagged as high risk, if appropriate.[24]

VHA established the High Risk for Suicide Patient Record Flag (PRF) to alert providers of patients at high risk for suicide. The System SPC is responsible for collaborating with the

[19] VA Office of Mental Health Services, "Suicide Prevention, Veterans Crisis Line." https://www.mentalhealth.va.gov/suicide_prevention/. (The website was accessed on May 25, 2018.)

[20] VA "Veterans Crisis Line (VCL) User Guide," December 2014. https://www.va.gov/vdl/documents/Clinical/Mental_Health/vcl_user_guide.doc. (The website was accessed on June 19, 2018.)

[21] VHA Directive 1503, *Operations of The Veterans Crisis Line Center,* May 31, 2017; VHA, National Suicide Prevention Center*, Suicide Prevention Coordinator Guide*, Version: January 5, 2018.

[22] VA/DoD, The Assessment and Management of Risk for Suicide Working Group, VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 1.0 – June 2013; VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, June 27, 2014, was rescinded and replaced by VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees,* December 22, 2017.

[23] VA Deputy Under Secretary for Health for Operations and Management, Memorandum - *High Risk for Suicide Patient Record Flag Changes*, October 3, 2017. This memo requires, *inter alia,* the use of the VHA *Self-Directed Violence (SDV) Classification System Clinical Tool* which can be found at VHA, *Self-Directed Violence (SDV) Classification System Clinical Tool*, https://www.mirecc.va.gov/visn19/docs/Clinical_tool.pdf. (The website was accessed on June 7, 2018.)

[24] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013; *VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 1.0;* Minneapolis VA HCS, Policy PE-01G, *Assessment of Patients,* April 10, 2014; Minneapolis VA HCS, Policy TX-18D.

patient's treating clinicians[25] to determine if a PRF should be placed.[26] Using a standardized risk assessment, the SPC and clinicians assess clinical indicators such as history of past suicide attempts, recent discharge from an inpatient MH unit, psychosocial factors, and physical disorders.[27] The SPC must enter a PRF into a patient's electronic health record (EHR), within 24 hours after making a determination that one is indicated.[28]

During admission and prior to all discharges, clinical staff must collaborate with patients at risk for suicide to complete a Suicide Prevention Safety Plan (Safety Plan).[29] The Safety Plan "provide[s] a pre-determined list of potential coping strategies as well as a list of individuals or agencies that veterans can contact in order to help them lower their imminent risk of suicidal behavior."[30] The Safety Plan lists individualized coping strategies, resources, referrals, support systems, ways to reduce access to lethal means, and other information focused on supporting the veteran during a crisis.[31]

## Observational Status

An observation patient in the System presents with a significantly unstable or disabling psychiatric condition that requires monitoring, evaluation, and short-term treatment to re-assess and determine the appropriate level of care.[32] An observational bed is an inpatient bed in which patients with medical, surgical, or MH conditions can be kept for extended monitoring, evaluation, and treatment. Extended monitoring, or observational status, must not exceed 47 hours and 59 minutes.[33] If the patient requires further inpatient care, staff contact the bed

[25] For the purposes of this report, "clinicians" include licensed independent providers, the Advanced Practice Registered Nurse, and registered nurses.

[26] VA Deputy Under Secretary for Health for Operations and Management, Memorandum - *High Risk for Suicide Patient Record Flag Changes*; VHA Directive 2010-053, *Patient Record Flags,* December 3, 2010. The VHA directive expired December 31, 2015 and has not been renewed**.**

[27] For example, psychosocial factors may include the loss of a job or marital issues; physical disorders may include chronic pain or traumatic brain injuries. VHA *Suicide Risk Assessment Guide Reference Manual,* (ND). The Manual is available on an internal VA website that is not available to the public. The Manual is embedded in VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. This directive expired July 31, 2013 and has not been renewed.

[28] VA Deputy Under Secretary for Health for Operations and Management, Memorandum - *High Risk for Suicide Patient Record Flag Changes*; VHA Directive 2008-036.

[29] VHA Handbook 1160.06; Minneapolis VA HCS, Standard Operating Procedure: *Inpatient Mental Health (1K) Discharge Planning and Follow-up*, September 14, 2017.

[30] VA, Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version, August 20, 2008.

[31] VA, Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version.

[32] VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014, amended August 25, 2017; Minneapolis VA HCS, Policy #TX–21F *Observation and Short Stay*, January 6, 2015.

[33] VHA Handbook 1160.06; VHA Directive 1036.

coordinator for formal admission to the inpatient MH unit and the responsible provider places the admission orders.[34]

## Admission to Inpatient Care

Once admitted to the inpatient MH unit, the System designates the inpatient Medical Director, Nurse Manager, Assistant Nurse Manager, and psychiatrist responsible for the admission and discharge processes.[35] (See also, Appendix A for information related to Advanced Practice Registered Nurses who may have responsibilities for admission and discharge.) Within 24 hours of admission, nursing staff complete the nursing assessment; a provider completes a history and physical examination.[36] VHA requires discharge planning to begin promptly after admission and to include provider-to-provider communication in facilitating post-discharge follow-up care.[37] System policy emphasizes communication between inpatient and outpatient providers to improve transfer of care. Specifically, the inpatient team is advised to contact the outpatient team within two working days of admission and to include the outpatient treatment team in discharge planning.[38]

## Interdisciplinary Treatment Team

VHA recognizes that inpatient staff must function as coordinated care teams to ensure optimal continuity of care and treatment effectiveness.[39] The System MH Lead is responsible for ensuring interdisciplinary collaboration in treatment planning, provision of clinical services, and discharge planning.[40] Each inpatient is assigned an interdisciplinary treatment team (ITT). The ITT is characterized by a "high degree of collaboration, communication, and interdependence" to ensure the treatment meets the patient's needs.[41] The ITT is responsible for the development and implementation of a treatment plan in collaboration with the patient, coordination of services with the patient's MH Treatment Coordinator (MHTC), and initiation and coordination of the discharge plan.[42] The System must assign every patient receiving MH services an MHTC, who serves as the principal MH provider responsible for maintaining regular contact with the patient,

[34] Minneapolis VA HCS, Policy #TX–21F, *Observation and Short Stay*.

[35] Minneapolis VA HCS, Memorandum #204A, Admission & Discharge from Inpatient Psychiatry, July 7, 2017.

[36] Minneapolis VA HCS, *Memorandum #204A.*

[37] VHA Handbook 1160.06.

[38] Minneapolis VA HCS, *Memorandum #204A.*

[39] VHA Handbook 1160.01, Uniform MH Services in VA Medical Centers and Clinics, November 16, 2015.

[40] VHA defines MH Lead as "Mental Health Service Line Director, discipline Service Chief, etc." VHA Handbook 1160.06.

[41] VHA Handbook 1160.06.

[42] VHA Handbook 1160.06.

regular psychiatric review, coordination of patient-centered inpatient and outpatient treatment plans, monitoring progress toward treatment goals, and collaboration with the SPC when appropriate.[43]

The System's outpatient MH programs are also organized by ITTs.[44] The inpatient ITT also assesses a patient's readiness to transition to a less restrictive care setting. Determining the appropriate care setting for a patient upon discharge from the inpatient MH unit must be a collaborative process that includes the patient, other ITT members, and family, if appropriate.[45]

## Assessment of Firearms Access

Sixty-six percent of male veteran suicides result from firearm injury.[46] Firearm-related suicide attempts are highly likely to be fatal compared to other means of suicide.[47] Nearly half of all veterans own at least one firearm and gun ownership is an independent risk factor for suicide.[48] Therefore, to determine a patient's risk for suicide, clinical guidelines include an assessment of the presence of, access to, or intent to acquire firearms.[49]

[43] VHA Handbook 1160.01; VA Deputy Under Secretary for Health for Operations and Management, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.

[44] Minneapolis VA Health Care System, Mental Health Services, https://www.minneapolis.va.gov/services/Mental_Health_Services.asp. (The website was accessed on August 13, 2018.); In the subject case, the MHTC also served as the Patient's outpatient Social Worker.

[45] VHA Handbook 1160.06; *VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 1.0*.

[46] Cleveland, E.C, Deborah Azrael, Joseph A. Simonetti, and Matthew Miller. "Firearm ownership among American veterans: findings from the 2015 National Firearm Survey." *Injury Epidemiology* 4:33. (December 2017); VHA, "Lethal Means Safety & Suicide Prevention - Facts that Matter," https://www.mirecc.va.gov/lethalmeanssafety/facts/. (The website was accessed on May 23, 2018.)

[47] VHA, "Lethal Means Safety & Suicide Prevention - Facts that Matter."

[48] Miller, M, S.A. Swanson, D. Azrael, "Are We Missing Something Pertinent? A Bias Analysis of Unmeasured Confounding in the Firearm-Suicide Literature," *Epidemiological Reviews*, 38 (January 2016) 62-69; Anestis, Michael D. "Statement for the American Association of Suicidology Regarding the Role of Firearms in Suicide and the Importance of Means Safety in Preventing Suicide Deaths" *American Association of Suicidology* (February 2018); Cleveland, E.C, Deborah Azrael, Joseph A. Simonetti, and Matthew Miller. "Firearm ownership among American veterans: findings from the 2015 National Firearm Survey." *Injury Epidemiology* 4:33. (December 2017).

[49] *VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 1.0.*

Limiting access to firearms is effective in reducing suicide mortality.[50] VA/DoD (Department of Defense) guidelines offer recommendations regarding assessing and limiting access to lethal means, stating explicitly that "[m]eans restriction is considered a key component in a comprehensive suicide prevention strategy…"[51] Patient education should include the importance of means restriction, particularly if a patient has talked about specific means for self-harm.[52] For patients at intermediate or high risk, clinicians should discuss safe storage of firearms, using locks or having a friend store the firearm.[53] During times of crisis, families may restrict the patient's access to firearms.[54]

## Family Treatment Engagement

VHA requires compliance with The Joint Commission (TJC) standards of quality and safety.[55] TJC requires that "the plan for care, treatment, and services addresses the family's involvement."[56] TJC also requires documentation of family involvement, with the patient's consent, unless clinically contraindicated.[57] Family involvement may be critical to successful discharge planning. Upon discharge, staff should provide suicide prevention information to the patient and family.[58]

Prior to discharge to a lower level of care, VA recommends providers educate the patient and family on the management of stressors that may contribute to suicidality. VA advises that

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[50] Mann, John J., Alan Apter, Jose Bertolote, Annette Beautrais, Diane Currier, Ann Hass, Ulrich Hegerl, Jouko Lonnqvist, Kevin Malone, Anrej Marusic, Lars Mehlum, George Patton, Michael Phillips, Wolfgang Rutz, Zoltan Rihmer, Armin Schmidtke, David Shaffer, Morton Silverman, Yoshitomo Takahashi, Airi Varnik, Danuta Wasserman, Paul Yip, Herbert Hendin, "Suicide Prevention Strategies – A Systematic Review" *American Medical Association Journal (JAMA)* 294 no. 16, (26 October, 2005): 2064 – 2074.

[51] *VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 1.0.*

[52] *VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 1.0.*

[53] *VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 1.0.*

[54] McCourt, Alexander D, Jon S. Vernick, Marian E. Betz, Sara Brandspigel, Carol Runyan, "Temporary Transfer of Firearms From the Home to Prevent Suicide – Legal Obstacles and Recommendations" Journal of the *American Medical Association (JAMA)* 177, no 1 (January 2017): 96 – 101; VHA, National Suicide Risk Management Consultation Program, "Lethal Means Safety & Suicide Prevention – Options" *Mental Illness Research, Education and Clinical Center – Centers of Excellence* - (9 July 2017). https://www.mirecc.va.gov/lethalmeanssafety/safety/. (The website was accessed on May 30, 2018.)

[55] The Joint Commission is an accrediting body that sets quality performance standards; VHA Directive 1100.16. *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017.

[56] The Joint Commission, *Behavioral Health Standard CTS.03.01.05* Effective date January 13, 2018.

[57] The Joint Commission, *CTS.03.01.0.5*

[58] The Joint Commission, *National Patient Safety Goals*, Effective date January 13, 2018.

education include information about suicide warning signs, the recommended treatment plan, contributing family factors, removal of lethal means, and emergency procedures.[59]

VHA recognizes that family members "must be involved in the Veteran's care to the extent appropriate."[60] VA-funded researchers found that deficits in communication with family and among providers account, in part, for the increased risk of death by suicide after discharge from an inpatient MH unit.[61] Consequently, in June 2017, VHA required MH inpatient and residential rehabilitation treatment programs to implement enhanced discharge planning processes related to family engagement, including asking every patient how best to engage family in discharge planning and the suicide risk assessment.[62]

The System requires clinicians to ask every patient to sign a release of information and work to increase family engagement in care plans.[63] Clinicians are required to document in the EHR efforts to identify next of kin, obtain a release of information, and engage family in treatment and discharge planning.[64]

## Discharge Planning

VHA requires discharge planning to begin promptly after admission. The inpatient ITT is responsible for arranging follow-up care and coordinating with the MHTC.[65] When a provider discharges a patient from an inpatient MH unit, VHA requires that an outpatient follow-up appointment is scheduled within seven days of discharge.[66] As part of the discharge process, the ITT must contact the outpatient treatment team within one or two working days of admission so that they can be involved in treatment and discharge planning.[67] For patients new to outpatient MH treatment, the inpatient ITT will schedule the patient for an appointment with a psychiatrist

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[59] *VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 1.0.*

[60] VHA Handbook 1160.06.

[61] Riblet, Natalie, Brian Shiner, Bradley V. Watts, Peter Mills, Brett Rusch, and Robin R. Hemphill. 2017. "Death by Suicide Within 1 Week of Hospital Discharge: A Retrospective Study of Root Cause Analysis Reports." *Journal of Nervous and Mental Disease* 205 (6): 436-442.

[62] VA Deputy Undersecretary for Health for Operations and Management, Memorandum - Eliminating Veteran Suicide: Enhancing Acute Inpatient Mental Health and Residential Rehabilitation Treatment Program (RRTP) Discharge Planning and Follow-up, June 12, 2017.

[63] Minneapolis VA HCS, Standard Operating Procedure: *Inpatient Mental Health (1K) Discharge Planning and Follow-up.*

[64] Minneapolis VA HCS, Memorandum #204A; Minneapolis VA HCS, *Standard Operating Procedure: Inpatient Mental Health (1K) Discharge Planning and Follow-up.*

[65] VHA Handbook 1160.06.

[66] VHA Handbook 1160.06.

[67] Minneapolis VA HCS, *Memorandum #204A*.

within one week of discharge. The inpatient ITT is required to discuss discharge plans, including anticipated needs and the tentative discharge date, at inpatient team meetings.[68]

### Clinical Documentation Requirements

VHA requires that all entries into a patient's EHR "be timely, relevant, necessary, complete, and authenticated."[69] Clinical documentation must include accurate and current data relevant to the patient's chief complaint(s), assessment, plan of care, diagnosis(es) treated during the encounter or that necessitate further treatment, medical rationale for ordering tests, consults, or changes to medication regimen, follow-up treatment, and patient instructions.[70] The documentation must be consistent with TJC's standards regarding "maintaining complete and accurate clinical records."[71] Additionally, the System's Office of Health Information Management and Health Records managers must have a protocol to audit and monitor clinical documentation.[72]

The System Management of Information Policy states, "[i]ndividual providers are responsible for the quality, completeness, clinical pertinence, and timeliness of their entries into the medical record."[73] The System's MH documentation policy identified responsible staff and requirements for documentation of PRFs, changes in levels of care, suicide risk assessments, MH consults, Suicide Behavior Reports (SBR), and Safety Plans.[74]

## SPC

In 2007, VHA required facilities to establish a full-time SPC role designated to implement suicide prevention strategies via education, data collection, and coordination of care.[75] VHA further defined the SPCs' responsibilities to include clinical coordination, enhanced training, and administrative oversight.[76]

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[68] Minneapolis VA HCS, *Memorandum #204A*.

[69] VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[70] VHA Handbook 1907.01.

[71] The Joint Commission E-dition Program: Behavioral Health, *Chapter; Record of Care, Treatment, and Services,* January 1, 2018. RC.01.01.01: The organization maintains complete and accurate clinical records.

[72] VHA Handbook 1907.01.

[73] Minneapolis VA HCS, *Policy IM-01K, Medical Records*, June 7, 2013.

[74] Minneapolis VA HCS, *Documentation Guidelines MH* (n.d.).

[75] VA Deputy Under Secretary for Health for Operations and Management, Memorandum -*Mental Health Funding for Suicide Prevention Coordinators*, February 8, 2007.

[76] VHA, National Suicide Prevention Center, *Suicide Prevention Coordinator Guide*.

### Clinical Responsibilities

The SPC determines, implements, and manages a facility's PRF assignments, and collaborates with providers who refer high-risk patients for a PRF.[77] System policy requires that prior to a patient's discharge from the inpatient MH unit, the ITT, SPC, and outpatient care team determine whether a "High Risk for Suicide" PRF should be placed.[78]

The SPC is also required to follow-up on VCL referrals. The SPC must have a dedicated phone line accessible to VCL staff, respond to referrals within one business day, meet the patient upon arrival to a facility to ensure timely evaluation and treatment (when possible), and close the initial VCL consult request.[79]

System policy also described the role of the Suicide Prevention Case Manager (SPCM).[80] The System SPC stated the SPCM reports to the SPC, monitors a caseload of high-risk patients identified by PRFs, and coordinates with providers to meet with high-risk patients in person or by telephone. The System SPC stated an SPCM is assigned to each MH inpatient and outpatient team.[81]

### Training Responsibilities

TJC recommends that organizations "[e]ducate all staff in patient care settings about how to identify and respond to patients with suicide ideation."[82] VHA requires the SPC to manage certain System employee education related to suicide prevention and Suicide Behavioral Reports (SBR).[83]

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[77] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. This directive expired July 31, 2013 and has not yet been renewed.

[78] Minneapolis VA HCS, *Policy TX-18D*.

[79] VHA, National Suicide Prevention Center, *Suicide Prevention Coordinator Guide*.

[80] Minneapolis VA HCS, *Policy TX-18D.* The SPCM works "closely with the SPC to monitor veterans on the high risk list."

[81] Minneapolis VA HCS, *Policy TX-18D.*

[82] The Joint Commission, Sentinel Alert Event. "Detecting and treating suicide ideation in all settings," February 24, 2016. https://www.jointcommission.org/assets/1/18/SEA_56_Suicide.pdf. (The website was accessed on May 9, 2018.)

[83] VA Deputy Under Secretary for Health for Operations and Management, Memorandum- *Suicide Awareness Training*, April 11, 2017; VA Deputy Under Secretary for Health for Operations and Management, Memorandum - *High Risk for Suicide Patient Record Flag Changes*, October 3, 2017.

In April 2017, VHA required mandatory annual suicide prevention training for all VHA employees.[84] Clinicians must complete a web-based VA Talent Management System (TMS)[85] course entitled *Suicide Risk Management Training for Clinicians*, followed by an annual refresher course.[86] In October 2017, VHA mandated the SPC also train clinical staff on the SBR to report all suicidal self-directed violent behaviors occurring within 12 months of the notification of the behavior.[87]

Nonclinical new employees are required to complete an SPC-led in-person "S.A.V.E."[88] training within the first 90 days of employment.[89] Thereafter, nonclinical staff are required to complete a web-based TMS refresher course annually.[90]

### Administrative Responsibilities

In November 2012, VHA implemented the Behavioral Health Autopsy Program (BHAP) requiring SPCs to complete an EHR review and analysis following a veteran's death by suicide within 30 days of their awareness.[91] SPCs conduct the analysis using an EHR template, the Behavioral Health Autopsy (BHA) that includes relevant historical events and medical history.[92]

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[84] VA Deputy Under Secretary for Health for Operations and Management, Memorandum - *Suicide Awareness Training*.

[85] VA Talent Management System, https://www.tms.va.gov/learning/user/login.jsp. (The website was accessed on June 15, 2018.)

[86] VHA Directive 1071. For the purposes of this Directive, "clinician" equates with "provider" and further defines provider as, "MD, DO, NP, PA, LCSW, Ph.D., RN, as well as any employee serving in the capacity of case manager or Vet Center team leader and counselor."; VA Deputy Under Secretary for Health for Operations and Management, Memorandum - *Suicide Awareness Training*.; VHA National Suicide Prevention Center, *Suicide Prevention Coordinator Guide*.

[87] VA Deputy Under Secretary for Health for Operations and Management, Memorandum - *High Risk for Suicide Patient Record Flag Changes*.

[88] S.A.V.E - **S**igns of suicidal thinking should be recognized, **A**sking about suicide, **V**alidating feelings, **E**ncouraging help, and **E**xpediting treatment. VHA, Suicide Prevention Resource Center, http://www.sprc.org/resources-programs/operation-save-va-suicide-prevention-gatekeeper-training. (The website was accessed on May 24, 2018.)

[89] VHA Directive 1071; VA Deputy Under Secretary for Health for Operations and Management, Memorandum - *Suicide Awareness Training*.

[90] VHA Directive 1071; VA Deputy Under Secretary for Health for Operations and Management, Memorandum - *Suicide Awareness Training*; VHA National Suicide Prevention Center, *Suicide Prevention Coordinator Guide*.

[91] VA Deputy Under Secretary for Health for Operations and Management, Memorandum - *Behavioral Autopsy Program Implementation,* December 11, 2012.

[92] VA Deputy Under Secretary for Health for Operations and Management, Memorandum - *Behavioral Autopsy Program Implementation*; VHA National Suicide Prevention Center, *Suicide Prevention Coordinator Guide*.

The SPC is also responsible for entering data monthly into the Suicide Prevention Application Network (SPAN) and Suicide Prevention Administrative Tracking.[93] The SPAN data includes information pertaining to clinical suicide prevention outreach and suicidal events, unless the individual was on active military duty.[94] The SPCs record nonclinical outreach, training, and follow-up in the Suicide Prevention Administrative Tracking.[95] VHA also assigns responsibility to the SPC for completing the Safety Plan for high-risk suicide patients.[96] SPCs are required to track all suicide attempts, ideation, and plans or behaviors using the SBR.[97]

### *System Suicide Awareness and Prevention Committee*

In December 2017, the System's MH Executive Committee implemented the Suicide Awareness and Prevention Committee (Committee) that includes 18 members and three ad hoc members, and reports to the Quality Management Council.[98] The purpose of the Committee is to "promote suicide awareness, prevention, and education at every opportunity by every employee, staff, student and volunteer interaction with Veterans and their families."[99]

The Committee co-chairs are responsible for remaining current on VHA policies, requirements and directives, and ensuring the System adheres to all suicide prevention requirements.[100] The Committee policy requires documentation of monthly meetings and planning and operational activities, including a summary of the Committee's deliberations, closed actions, and future actions with expected date of completion.[101]

## Administrative Reviews

See Appendix A for additional information related to System administrative review requirements.

## Prior OIG Reports

An OIG search did not reveal reports pertaining to the System with the same or similar topics published within the last three years. However, a July 2012 OIG report reflects issues similar to the current subject report: *Service Delivery and Follow-up After a Patient's Suicide Attempt,*

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[93] VHA National Suicide Prevention Center, *Suicide Prevention Coordinator Guide*.

[94] VHA, National Suicide Prevention Center, *Suicide Prevention Coordinator Guide*.

[95] VHA, National Suicide Prevention Center, *Suicide Prevention Coordinator Guide*.

[96] VHA, National Suicide Prevention Center, *Suicide Prevention Coordinator Guide*.

[97] Minneapolis VA HCS, *Policy TX-18D;* VHA, National Suicide Prevention Center, *Suicide Prevention Coordinator Guide*.

[98] Minneapolis VA HCS, Policy #PI-24, *Suicide Awareness and Prevention Committee*, December 11, 2017.

[99] Minneapolis VA HCS, Policy #PI-24.

[100] Minneapolis VA HCS, Policy #PI-24.

[101] Minneapolis VA HCS, Policy #PI-24.

*Minneapolis VA Health Care System, Minneapolis, Minnesota*, (Report No. 12-01760-230). The report was issued in response to allegations concerning MH medication management and discharge planning at the System.

The OIG found in the 2012 report that the SPC did not participate in the evaluation and ongoing monitoring of the patient, and the treatment team did not complete a suicide risk assessment at the time of the patient's discharge. In addition, the staff did not place the patient on the high-risk list or initiate a PRF.

The OIG made eight recommendations, all of which are now closed. The following four recommendations are relevant to the current OIG report:

- The OIG recommended the Minneapolis VA Health Care System Director require the Suicide Prevention Coordinator to take a proactive role in assessing and managing patients at high risk for suicide and/or with recent suicide attempts.
- The OIG recommended that the Minneapolis VA Health Care System Director take action to require the Suicide Behavior Committee to document discussions and actions in meeting minutes and forward to appropriate clinical managers for review and oversight.
- The OIG recommended that the System Director, Minneapolis VA Health Care System Director take action to update the appropriate suicide prevention and Patient Record Flag policies in accordance with VHA guidance.
- The OIG recommended that the System Director, Minneapolis VA Health Care System Director take action to assure that System staff receive training on VHA's administrative requirements and processes for managing patients at high risk for suicide.

## Request for Review

In 2018, Representative Tim Walz requested the OIG review the inpatient care provided to the Patient whom VA Police found deceased from a self-inflicted gunshot wound less than 24 hours after discharge from the System's inpatient MH unit.

Additionally, the OIG team reviewed System leaders' actions following the Patient's death.

# Scope and Methodology

The OIG initiated the inspection in March 2018, with site visits April 23, 2018, through April 25, 2018.

The OIG inspection team reviewed VHA and System policies and procedures for the applicable periods in 2017 and 2018 related to inpatient admission and coordination of care, assessment of lethal means, family engagement in treatment, discharge processes, clinical documentation, administrative review, and suicide prevention coordination and training. The OIG team also reviewed relevant empirical literature, including guidelines and recommendations from TJC and The American Academy of Suicidology.

Also reviewed were relevant meeting minutes, RCAs and issue briefs, EHRs, suicide reporting data, police reports, email communications, and staff training records. The OIG team reviewed entries made in the Patient's EHR for the seven months prior to death, as well as relevant closed-circuit television video recordings, and the Medical Examiner's Autopsy Report.

Interviews were conducted with System leaders, inpatient MH managers and clinical staff, the MH inpatient provider,[102] SPCs and an SPCM, the Patient Safety Manager, a VA police officer, and the MHTC/social worker involved in the Patient's care.

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

[102] The Patient's inpatient provider was an Advanced Practice Registered Nurse functioning under an agreement with a System psychiatrist.

# Patient Case Summary

The Patient, who was more than 30-years-old, was found dead from a self-inflicted gunshot wound in the parking lot of the System's main hospital by the VA police less than 24 hours after discharge from the inpatient MH unit.

## Day 1: Observation Status

On a day in 2018 (Day 1), the Patient called the VCL and reported suicidal thoughts and having "immediate access to guns." The VCL responder discussed options of limiting access to the guns. The Patient appeared willing to have someone else keep the guns but stated this arrangement could not be done immediately. The Patient and a VCL crisis worker developed a Safety Plan that included going to the System emergency department (ED). As planned, the Patient was seen at the ED that same day. A psychiatrist evaluated the Patient who reported being kicked out of the home earlier that day that was shared with a significant other for two years. The Patient was feeling overwhelmed, helpless, and did not know what to do. Other stressors included unhappiness at work and debt related to medical bills from a motor vehicle accident the previous year. The Patient reported having no friends to "call on;" the Patient's parents were not available for support because one parent was caring for the other parent who was ill. The Patient's mood was "down" and appeared frustrated, discouraged, and tearful at times. Sleep was variable with intermittent awakening and anxiety related to a previous deployment to Iraq.[103] The Patient admitted to suicidal thoughts and had a plan to suicide with a gun. By the Patient's report, guns were accessible, and the Patient had put a gun to his/her head in the past.[104]

The ED psychiatrist documented that the Patient had received a few psychotherapy sessions with an outpatient social worker and the last session was two months prior. The outpatient social worker was also the Patient's MHTC. The Patient reported a family history of depression but did not report active substance use symptoms. There was no documented family history of suicidal behavior. The psychiatrist diagnosed the Patient with adjustment disorder with mixed emotions, unspecified anxiety disorder, and likely borderline personality disorder as determined through a review of a 2017 psychology consult. The psychiatrist completed an order for an observation admission for "safety, stabilization, and crisis management."[105] The psychiatrist recommended medication as needed for sleep and agitation (subsequently ordered by another physician),

[103] The Patient received a structured assessment for Post-Traumatic Stress Disorder (PTSD) via the PTSD Symptom Scale Interview in late 2017. The SW who administered the scale documented the Patient "does have some symptoms of PTSD but doesn't meet full criteria at this time."

[104] The OIG uses gender neutral language to protect patients' privacy.

[105] VHA Directive 1036.

completed a safety risk assessment, and documented risk as "[l]ow or [*sic*] in hospital but unclear outside of hospital."

## Day 2: Observation Status

An inpatient MH Nurse Practitioner (NP) documented that the Patient continued to express suicidal ideations and was unable to identify a purpose or meaningful reason for living. The Patient reported being unable to attend previously recommended outpatient groups due to scheduling conflicts with work. The NP documented that the Patient was "quite distressed" with irritability, difficulty sleeping, and navigating everyday life, and a "lengthy period of low motivation." The NP documented that the Patient's mood was depressed and hopeless but noted that the Patient was amenable to starting an antidepressant. The Patient reported that one parent was prescribed antidepressant medication but did not want to confer with the parent about which medication had worked.

Later that night, a nurse (Nurse 1) documented that the Patient asked about, "what the plan is." Nurse 1 advised the Patient to speak with a team member the next day and the Patient appeared reassured by this guidance. The Patient was pleasant, calm, and appreciative of care; mood was euthymic and suicidal ideations were denied.[106]

## Day 3: Inpatient MH Admission

In the morning, the NP evaluated the Patient and documented that the Patient was not suicidal. The level of hopelessness had "softened;" the Patient was less anxious in general although had difficulty with sleep. Documentation in the NP's discharge summary indicated that the Patient participated in groups and interacted with peers on the unit by Day 3. The NP prescribed a sleep medication. The NP also completed an order to change the Patient from an observation admission to a full admission and targeted discharge for the next day.

The Patient told an inpatient social worker about being concerned with housing and had reservations about staying with family (parents). The social worker documented a discussion about housing including efforts to "normalize" the need to rely on family while stabilizing the Patient's housing situation. The social worker encouraged the Patient to consider previously recommended outpatient group therapy.

In a "mental health team conference" note, an SPCM acknowledged awareness of the Patient's admission. The SPCM also documented that assignment of a flag indicating high-risk for suicide would be determined following further stabilization, treatment and disposition planning, and

[106] Euthymic refers to "a normal, tranquil mental state or mood." Miriam-Webster Medical Dictionary, https://www.merriam-webster.com/medical/euthymic. (The website accessed on June 20, 2018.)

consultation with providers. An SPC or SPCM did not enter additional EHR documentation during the Patient's admission.

In the afternoon, Nurse 2 completed a change in level of care note, which converted the Patient from an observation admission to a full admission. Nurse 2 documented that the Patient was depressed and tearful at times. The Patient denied suicidal ideation, discussed wanting help, and would like to have a plan before discharge. Nurse 2 also completed a treatment plan note for which the Patient's outpatient social worker was the only additional signer.

In the evening, Nurse 1 documented that the Patient denied suicidal ideation and appeared more relaxed because there was a plan for discharge. The Patient reported looking forward to being discharged the next day stating, "it gets kinda [*sic*] charged up in here."

## Day 4: Discharge

In a "disposition/handoff communication" note, the NP documented that the Patient requested discharge. The NP wrote that the "patient does not currently meet dangerousness criteria for a 72-hour hold or petition for commitment because [the Patient] denies intent to kill or harm self or others, has shown no evidence of aggressive behavior or dangerousness since stabilization…and is agreeable to continuing with outpatient care." The NP assessed the Patient's suicide risk as "intermediate/moderate risk" and did not include other providers as additional signers to this note. The NP documented putting a "call out" to the Patient's outpatient social worker. There is no documentation communicating medication management recommendations. The inpatient MH nurse manager coordinated the scheduling of an outpatient appointment for approximately seven days later with a social worker.

On the day of discharge, the Patient described feeling "hopeful" and stated, "[i]t sounds corny but yeah, it is hopeful." The Patient denied immediate access to a firearm, but reported that he/she, "could have obtained one." In reference to a plan to attend recommended therapy groups, the Patient stated, "missing a couple of hours of work for therapy is certainly better than missing an entire week of work due to the need for hospitalization." The NP documented a suicide risk assessment in the discharge summary that determined the Patient was a low risk.

The inpatient social worker documented that discharge would be to the home of the Patient's parents. The Patient agreed to consider the previously recommended outpatient group therapy and completed a Safety Plan. The Patient's outpatient social worker was an additional signer to the inpatient social worker's discharge note.

Nurse 2 documented a Safety Plan prior to discharge that included, "Take responsibility for safety at home: Remove the means from your home whenever possible (such as firearms)."

## Day Five: Post-Discharge

VA police found the Patient deceased by a self-inflicted gunshot wound to the head in the parking lot of the System's main hospital. The Medical Examiner determined the cause of death to be injuries related to a gunshot wound to the head, and the manner of death as suicide.

# Inspection Results

## Issue 1: Care Coordination

The OIG team determined that the inpatient MH staff failed to

- Include the Patient's outpatient treatment team in discharge planning,[107]
- Identify an outpatient prescriber and schedule an outpatient medication management follow-up appointment,[108]
- Adequately document assessment of firearms and educate the Patient on limiting access to firearms, and[109]
- Document the Patient's declination to engage family in treatment planning and discharge planning.[110]

The OIG team determined that the Patient's ITT did not adequately communicate with the outpatient treatment team regarding discharge planning. Clinicians included the Patient's outpatient MHTC as an additional signer on the SBR, MH Treatment Plan, and social worker's discharge note. The inpatient ITT did not communicate with the MHTC in additional documentation related to discharge planning including psychiatric notes, nursing progress notes, change in level of care notes, MH team conference note, MH Safety Plan, and MH disposition/hand-off note. The MH NP attempted but did not reach the Patient's MHTC by phone on the day of discharge.

The OIG team determined that the inpatient ITT failed to identify an outpatient prescriber to continue management of a newly prescribed medication. The MH NP initiated treatment with an antidepressant medication on Day 2. At the time of discharge, the MH NP documented follow-up with the outpatient social worker within seven days of discharge but failed to arrange outpatient medication management follow-up.

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[107] VHA Handbook 1160.06; Minneapolis VA HCS, *Policy TX-18D*; Minneapolis VA HCS, *Memorandum #204A*.

[108] VHA Handbook 1160.06.

[109] VHA, Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version: August 20, 2008; VA/DoD, The Assessment and Management of Risk for Suicide Working Group, *VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide, Version 1.0.*

[110] VA Deputy Undersecretary for Health for Operations and Management, Memorandum - Eliminating Veteran Suicide: Enhancing Inpatient Mental Health and Residential Rehabilitation Treatment Program (RRTP) Discharge Planning and Follow-up; Minneapolis VA HCS, Standard Operating Procedure: *Inpatient Mental Health (1K) Discharge Planning and Follow-up*.

Proper documentation is necessary for sound clinical decision making.[111] In addition to the documentation omissions noted above, the OIG team identified that the Patient's EHR from this episode of care[112] contained inconsistent and contradictory documentation regarding the Patient's access to firearms or other lethal means.[113] (See Table 1.) The Patient told the VCL responder about having immediate access to a firearm and stated the firearm could not be immediately secured. The Patient agreed to go to the System ED.

Documentation from the ED and throughout the Patient's admission include inconsistent reports of access to firearms. Three of nine clinicians documented the Patient had access to firearms and four documented "no" or "unknown." Nurse 1 documented that the Patient did not have a specific plan for suicide but documented "yes" to having "means to carry out the suicide plan." The SPC who completed the VCL consult did not include an assessment of firearms access. An SPCM placed an SBR documenting "unknown" access to guns. In the same note however, the SPCM wrote, "Per H&P [history and physical]: states thoughts of suicide are prominent…has access to guns and has had thoughts of suicide via guns…thought about lots of other ways." The MH NP stated that the Patient denied having a gun but acknowledged having the ability to access one in both the initial meeting and before discharge.

**Table 1. Documentation of the Patient's Access to Firearms**

| Date | Author | Does Patient Have Access to Firearms? | | |
|---|---|---|---|---|
| Day 1 | VCL Responder | Yes | | |
| Day 1 | ED Social Worker | Yes | | |
| Day 1 | ED RN | | No | |
| Day 1 | ED H&P | Yes | | |
| Day 1 | Inpatient RN/Nurse 1 | | | Unclear |
| Day 2 | SPC | | | Not Assessed |
| Day 2 | SPCM | | | Unknown |
| Day 3 | Inpatient RN/Nurse 2 | | No | |
| Day 4 | Inpatient NP | | No | |
| **TOTALS** | | **3** | **3** | **3** |

*Source: VA OIG analysis of the Patient's EHR*

Clinicians did not document discussions with the Patient regarding securing and limiting access to weapons or efforts to contact family to secure weapons. Although the Safety Plan template

[111] VHA Handbook 1907.01.

[112] The Patient's episode of care began on Day 1 with the Veterans Crisis Line contact and ended with inpatient admission discharge on Day 4.

[113] Although System clinicians documented different information from the Patient, the OIG team did not find evidence that the ITT reconciled the discrepancies.

includes a statement regarding limiting lethal means, Nurse 2 reported the Patient did not assess firearms access or discuss limiting access with the Patient. The inpatient social worker and Nurses 1 and 2 told the OIG that they did not document asking the Patient directly about firearms. The MH NP assessed the Patient's access to firearms upon discharge and the Patient denied access at that time. The OIG team did not find documentation of discussions with the Patient or the family related to securing firearms.

The OIG determined that the inpatient ITT did not document efforts to engage family or the Patient s declination to include family in treatment or discharge planning. VHA requires that clinicians ask every patient how best to engage family both in the suicide risk assessment and in discharge planning.[114] The inpatient MH unit Nurse Manager and social worker stated that they believed that the Patient did not want family involved in treatment but did not recall asking the Patient directly. The inpatient NP documented that the Patient did "not wish to confer with" one of the parents about antidepressant medications. There is, however, no evidence of efforts to obtain a release of information or discuss the benefits of family involvement. The OIG team found no documentation that reflected attempts to engage family in treatment or safety planning over the course of the Patient's admission. Although discharged to the home of the Patient's parents, the OIG did not find evidence in the Patient's EHR that clinicians documented efforts for release of information to contact the family to confirm the discharge plan. Staff told the OIG that they did not have discussions with the Patient about contacting family prior to discharge. The Suicide Risk Assessment completed at the time of discharge identified the Patient's risk as intermediate/moderate and did not include an assessment of how best to engage the family.

The OIG identified deficits in the care provided to the Patient related to team communication, treatment and discharge planning, and assessing access to firearms. The team, however, was unable to determine that any of these, alone or in combination, was a causal factor in the Patient's death.

## Issue 2: SPC

The OIG team determined that the System Suicide Prevention Coordinator did not

- Collaborate with the Patient's ITT during admission or participate in discharge planning,
- Determine the need for a PRF prior to discharge, or
- Provide SBR training to System clinical staff.

[114] VA Deputy Undersecretary for Health for Operations and Management, Memorandum - Eliminating Veteran Suicide: Enhancing Inpatient Mental Health and Residential Rehabilitation Treatment Program (RRTP) Discharge Planning and Follow-up.

In the course of this inspection, the OIG team also found that the Suicide Prevention Coordinator did not submit required Behavioral Health Autopsies (BHAs) within established VHA timeframes.

## Clinical Responsibilities

The OIG team determined that the SPC and ITT did not collaborate during the Patient's admission and the SPC did not participate in discharge planning.[115]

On Day 1, the Patient contacted the VCL, which resulted in an admission to the System's inpatient MH unit. On Day 3, a SPCM documented awareness of the Patient's admission and that assignment of a PRF would be "...determined following further stabilization, [treatment] and disposition planning and consultation with providers." On Day 4, the inpatient MH provider discharged the Patient, noting an intermediate/moderate suicide risk. Additionally, the same provider noted on the discharge summary that the Patient's risk was low.

The OIG determined that the SPC did not re-evaluate the Patient for a PRF prior to discharge, per System policy.[116] The SPCM told the OIG that a review of the EHR and patients' treatment and discharge plans was performed daily. The SPC and SPCM reported being unaware of the Patient 's discharge status, and there was no documentation that the discharging clinicians notified the SPC. Additionally, the SPC told the OIG that SPC staff do not receive notification of discharges but explained that "we just see it [in the EHR]."

## Training Role

The OIG team determined that not all clinical staff received SBR training, as required,[117] and that only the Social Work Service maintained SBR competencies. Additionally, SBR training was not a component of the System's New Employee Orientation and S.A.V.E. trainings, although the SPC told the OIG team that SBR was included.

The OIG identified deficits in the care provided to the Patient related to SPC collaboration during admission and discharge planning, assessing for PRF prior to discharge, and clinician training on SBR. The team was unable, however, to determine that any of these problems, alone or in combination, was a causal factor in the Patient's death.

## Administrative Role

A review of a sample of the System's 2017 and 2018 BHAs identified that the SPC failed to submit four of the 18 (22 percent) BHAs within 30 days of notification of the death. The SPC

[115] Minneapolis VA HCS, *Policy TX-18D*; VHA Handbook 1160.06; VHA Directive 2008-036.

[116] Minneapolis VA HCS, *Policy TX-18D;* Minneapolis VA HCS, *Documentation Guidelines MH* (n.d.).

[117] VA Deputy Under Secretary for Health Operations and Management. Memorandum - *High Risk for Patient Record Flag Changes*.

submitted the delayed BHAs an average of 6.5 days late with a range of 3 to 16 days. The System SPC completed the Patient's BHA within three days of the notification date.

The OIG reviewed a sample of the monthly 2018 Committee meeting minutes and found 17 of 18 discussion topics tasked to Committee members and corresponding issue status. The Committee's minutes did not include documentation of action item due dates or follow-up actions as required by the Committee policy.

### Issue 3: Administrative Reviews

The System Patient Safety Manager initiated and completed an RCA to review events related to the Patient's care. The OIG determined that the Patient Safety Manager included two individuals on the team who were directly involved in the event under review.[118]

Additionally, the OIG found that the RCA team conducted only two interviews and failed to interview several clinicians with direct knowledge of the Patient's inpatient and outpatient MH services. Further, the RCA team did not identify a root cause for the suicide.

## Conclusion

The OIG team determined that inpatient MH staff failed to

- Include the Patient's outpatient treatment team in discharge planning,[119]
- Identify an outpatient prescriber and schedule an outpatient medication management follow-up appointment,
- Adequately document assessment of firearms access and educate the Patient on limiting access to firearms, and[120]
- Document the Patient's declination to engage family in treatment planning and discharge planning.[121]

The OIG team determined that the inpatient ITT failed to identify an outpatient prescriber to continue management of a newly prescribed medication. The MH NP initiated treatment with an antidepressant medication on Day 2. At the time of discharge, the MH NP documented follow-up

[118] VHA Handbook 1050.01.

[119] VHA Handbook 1160.06; Minneapolis VA HCS, *Memorandum #204A*.

[120] VHA, Safety Plan Treatment Manual to Reduce Suicide Risk: Veteran Version: August 20, 2008; *VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide*, Version 1.0.

[121] VA Deputy Undersecretary for Health for Operations and Management, Memorandum - Eliminating Veteran Suicide: Enhancing Inpatient Mental Health and Residential Rehabilitation Treatment Program (RRTP) Discharge Planning and Follow-up; Minneapolis VA HCS, Standard Operating Procedure: *Inpatient Mental Health (1K) Discharge Planning and Follow-up.*

with the outpatient social worker within seven days of discharge but failed to arrange outpatient medication management follow-up. The OIG team also identified that the Patient's EHR contained inconsistent and contradictory documentation regarding the Patient's access to lethal means.[122] The OIG team, however, was unable to determine that any of these, alone or in combination, was a causal factor in the Patient's death.

The OIG team further determined that the System SPC did not

- Collaborate with the Patient's ITT during admission or participate in discharge planning,
- Determine the need for a PRF (high risk for suicide) prior to discharge,
- Provide Suicide Behavior Report training to System clinical staff, or
- Submit BHAs within required timeline.

The OIG team determined that the SPC and ITT did not collaborate during the Patient's admission and the SPC did not participate in discharge planning.[123] The OIG determined that the SPC did not re-evaluate the Patient for a PRF prior to discharge, per System policy.[124] The OIG found that the SPC was unaware of the Patient's discharge status, and there was no documentation that the discharging clinicians notified the SPC.

The OIG team determined that not all clinical staff received required SBR training and that only the Social Work Service maintained competencies.[125]

The OIG identified deficits in the care provided to the Patient related to SPC collaboration during admission and discharge planning; assessment for PRF prior to discharge, and clinician training on SBR. However, the OIG team was unable to determine that any of these, alone or in combination, was a causal factor in the Patient's death.

The OIG reviewed a sample of the System's 2017 and 2018 BHAs and found that the SPC did not submit four of the 18 (22 percent) BHAs within the required 30 days after the notification of death. The OIG found that the SPC timely completed the Patient's BHA within three days of the notification date.

The OIG reviewed a sample of monthly 2018 Committee meeting minutes and found 17 of 18 discussion topics tasked to Committee members and corresponding issue status. The

[122] Although System clinicians documented different information from the Patient, the OIG team did not find evidence that the ITT reconciled the discrepancies.

[123] Minneapolis VA HCS, *Policy TX-18D*; VHA Handbook 1160.06; VHA Directive 2008-036.

[124] Minneapolis VA HCS, *Policy TX-18D;* Minneapolis VA HCS, *Documentation Guidelines MH* (n.d.).

[125] Deputy Under Secretary for Health Operations and Management, Memorandum - *High Risk for Suicide Patient Record Flag Changes.*

Committee's minutes did not include documentation of action item due dates or evidence of follow-up, as required by the Committee policy.

The System Patient Safety Manager initiated and completed an RCA to review events related to the Patient's care. The OIG determined that the Patient Safety Manager included two individuals on the team who were directly involved in the event under review.[126]

Additionally, the OIG found that the RCA team conducted only two interviews and failed to interview several clinicians with direct knowledge of the Patient's inpatient and outpatient MH services. Further, the RCA team did not identify a root cause for the suicide.

The OIG made seven recommendations.

[126] VHA Handbook 1050.01.

# Recommendations 1–7

1. The Minneapolis VA Health Care System Director ensures that processes are strengthened for consistent Mental Health interdisciplinary collaboration across levels of care in treatment planning, provision of clinical services, and discharge planning (including medication management), as required by Veterans Health Administration.
2. The Minneapolis VA Health Care System Director ensures that all Mental Health interdisciplinary treatment team members, including the Suicide Prevention Coordinators and the outpatient care team, determine a patient's "High Risk for Suicide" Patient Record Flag status prior to discharge.
3. The Minneapolis VA Health Care System Director ensures that Mental Health clinical documentation is accurate and includes documented attempts to obtain release of information and engage family in treatment, and documentation of lethality.
4. The Minneapolis VA Health Care System Director verifies that all clinicians receive required training for Suicide Behavior Reporting.
5. The Minneapolis VA Health Care System Director verifies that Suicide Prevention Coordinators complete Behavioral Health Autopsies within established Veterans Health Administration timeframes.
6. The Minneapolis VA Health Care System Director ensures that the Suicide Awareness Prevention Committee document action items, follow up plans and identifies responsible staff.
7. The Minneapolis VA Health Care System Director ensures that processes be strengthened to ensure the root cause analysis process is performed consistent with Veterans Health Administration requirements.

# Appendix A: Additional Background

## Advanced Practice Registered Nurse

An Advanced Practice Registered Nurse (APRN) is a graduate-level nurse with additional training in a specific discipline. The four APRN roles are certified nurse midwife, certified registered nurse anesthetist, clinical nurse specialist, and nurse practitioner (NP). APRNs can also obtain certifications to treat special populations: Family, Adult-Gerontology, Neonatal, Pediatrics, Women's Health/Gender-Related, and Psychiatric-Mental Health.[127]

In September 2017, VHA established full practice authority for certain APRNs, including Certified Nurse Practitioners, within their scope of practice. Although not mandatory, VHA facility leaders can implement full practice authority without clinical supervision or mandatory collaboration of a physician; and medical bylaws must be consistent with the directive.[128,129]

The System's Medical Bylaws did not allow NPs full practice authority and required a written prescriptive collaborative agreement (Agreement) with a physician.[130] The Agreement defines delegated responsibilities, consistent with scope of practice, and identifies the primary collaborating physician. The Agreement outlines prescribing authority, allowable orders, and functions such as discharging patients, and performing history and physical examinations.[131]

## Administrative Reviews

### Sentinel Events

TJC defines a sentinel event as a patient safety event that "results in death, permanent harm, or severe temporary harm and intervention required to sustain life."[132] VHA requires "…immediate

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[127] RegisteredNursing.Org. *Advanced Practice Registered Nurse, (APRN)*.https://www.registerednursing.org/aprn/#aprn. (The website was accessed on June 1, 2018.)

[128] VHA Directive 1350, Advanced Practice Registered Nurse Full Practice Authority, September 17, 2017.

[129] American Association of Nurse Practitioners. "Issues at a Glance: Full Practice Authority." Full practice authority allows nurse practitioners to perform a full range of functions, including prescribing medications, under the exclusive licensure authority of the state board of nursing, February 2017.

https://mn.gov/boards/nursing/advanced-practice/advanced-practice-registered-nurse-(aprn)-licensure-general-information. (The website was accessed on June 1, 2018.)

[130] Minneapolis VA HCS, Medical Staff Bylaws, October 19, 2011; Minneapolis VA HCS, Medical Staff Bylaws, March 15, 2018.

[131] Minneapolis VA HCS, Policy # *HR-14H, Advanced Practice Registered Nurses*, August 11, 2015.

[132] The Joint Commission, "Sentinel Event Policy and Procedures." https://www.jointcommission.org/sentinel_event_policy_and_procedures/. (The website was accessed on April 10, 2018.)

investigation and response" to sentinel events through a root cause analysis (RCA) process and other administrative actions, such as an administrative investigative board.[133] VHA provides VISNs and facilities authority to decide whether to report sentinel events to TJC.[134] VISN 23 and the System did not require sentinel event reporting to TJC.[135]

## RCAs and Issue Briefs

A RCA is a multidisciplinary team approach to identify factors that contribute to healthcare-related adverse events.[136] The RCA must "[i]dentify at least one root cause with a corresponding action and outcome measure."[137] Per System policy, the Patient Safety Manager coordinates RCAs.[138] The RCA team must not include individuals directly involved with the event under review. The RCA team should interview individuals with direct knowledge and experience of the event as part of the process.[139]

Issue briefs provide information intended to allow leaders to understand relevant policy requirements and determine whether the provided care met those requirements. VHA and VISN 23 policies specify certain events that trigger the requirement for an issue brief. These events include suicide or suicide attempts meeting certain criteria, such as occurring on VA property, and suicides within seven days of discharge.[140]

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[133] VHA defines the RCA process as "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events…" VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. This handbook was scheduled for recertification on or before the last working day of March 2016 and has not been renewed.

[134] VHA Handbook 1050.01.

[135] VA Midwest Health Care Network (VISN 23), Network Policy V23-DND-018, *Urgent Communication Policy*, March 8, 2016; Minneapolis VA HCS, Policy #PI-03B, *Patient Safety Program and Patient Incident Reporting,* January 30, 2017.

[136] VA National Center for Patient Safety, "Root Cause Analysis," November 15, 2017. https://www.patientsafety.va.gov/professionals/onthejob/rca.asp. (The website was accessed on June 7, 2018.)

[137] VHA Handbook 1050.01

[138] Minneapolis VA HCS, Policy PI-01F*, Quality, Safety and Value Framework*, July 23, 2015

[139] VHA Handbook 1050.01.

[140] VA Deputy Undersecretary for Health for Operations and Management, Memorandum - *10N Guide to VHA Issue Briefs,* June 26, 2017*;* VA Midwest Health Care Network (VISN 23), *Network Policy V23-DND-018, Urgent Communication Policy,* March 8, 2016.

# Appendix B: VISN Director Comments

**Department of Veterans Affairs Memorandum**

Date: September 13, 2018

From: Acting Director, VA Midwest Health Care Network (VISN 10N23)

Subj: Healthcare Inspection— Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide, Minneapolis VA Health Care System, Minnesota

To: Director, VAOIG Office of Healthcare Inspections, Baltimore MD (54BA)

Director, Management Review Service (VHA 10E1D MRS Action)

I have reviewed and concur with each recommendation and action plan with target completion dates.

(Original signed by:)

Patrick J. Kelly, FACHE
Acting Network Director

# Appendix C: System Director Comments

**Department of Veterans Affairs Memorandum**

Date: September 7, 2018

From: Acting Director, Minneapolis VA Health Care System (618/00)

Subj: Healthcare Inspection— Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide, Minneapolis VA Health Care System, Minnesota

To: Director, VAOIG Office of Healthcare Inspections, Baltimore MD (54BA)

Thru: Acting Network Director (VISN 23)

I have read the Healthcare Inspection report and concur with the findings. Attached are the responses and action plans for each of the recommendations set forth by the OIG.

(Original signed by:)

DARWIN G. GOODSPEED, FACHE
Acting Director, Minneapolis VA HCS

# Comments to OIG's Report

## Recommendation 1

The Minneapolis VA Health Care System Director ensures that processes be strengthened to ensure MH interdisciplinary collaboration across levels of care in treatment planning, provision of clinical services and discharge planning, including medication management, as required by VHA.

Concur.

Target date for completion: 10/31/18

### Director Comments

The facility will develop and implement discharge summary from Inpatient Psychiatry to include: Follow up appointments for medication management and therapy. Additionally, all Mental Health clinical staff will be notified of the Mental Health Service Line Memorandum #204A, Admission & Discharge from Inpatient Psychiatry.

## Recommendation 2

The Minneapolis VA Health Care System Director ensures that all MH interdisciplinary treatment team members, including the Suicide Prevention Coordinators and the outpatient care team, determine a patient's "High Risk for Suicide" Patient Record Flag status prior to discharge.

Concur in Principle.

Target date for completion: 12/31/18

### Director Comments

Every admission to the inpatient MH unit does not clinically need an assessment for placing a "High Risk for Suicide" Patient Record Flag. For example, a dementia patient admitted for medication management would not clinically necessitate this type of assessment. For inpatient where this level of assessment is indicated, the Suicide Prevention Program staff will document the decision to assign a high risk for suicide flag after appropriate information is obtained regarding risk assessment, discharge plan and outpatient care plan. Local policies will be reviewed to ensure compliance with national guidance/policy and best practices.

## Recommendation 3

The Minneapolis VA Health Care System Director ensures that MH clinical documentation is accurate and includes documented attempts to obtain release of information and engage family in treatment, and documentation of lethality.

Concur.

Target date for completion: 9/30/18

### Director Comments

The Inpatient Psychiatric Nursing Data Base will include in admission assessment a request to the patient for ROI and/or family engagement/involvement in treatment plan and be documented in the health record. Additionally, the discharge orders will include discussion with the patient regarding access to firearms and harm reduction and be documented in the health record.

## Recommendation 4

The Minneapolis VA Health Care System Director verifies that all clinicians receive required training for Suicide Behavior Reporting.

Concur.

Target date for completion: 12/31/18

### Director Comments

Suicide Behavior Reporting will be added to the annual TMS required class Suicide Risk Management for Clinicians.

## Recommendation 5

The Minneapolis VA Health Care System Director verifies that Suicide Prevention Coordinators complete Behavioral Health Autopsies within established VHA timeframes.

Concur.

Target date for completion: 9/30/18

### Director Comments

The Suicide Prevention staff will complete all BHA within 30 days post notification.

## Recommendation 6

The Minneapolis VA Health Care System Director ensures that the Suicide Awareness Prevention Committee document action items, follow up plans and identifies responsible staff.

Concur.

Target date for completion: 10/15/18

### Director Comments

All Suicide Awareness Prevention meeting minutes will reflect expectations of documented action items, follow-up plans and identifies responsible staff. In addition, the Suicide Prevention Program will be reviewed by Mental Health leadership to ensure that there is appropriate leadership and oversight for the program as well as ensuring the program follows national directives.

## Recommendation 7

The Minneapolis VA Health Care System Director ensures that processes be strengthened to ensure the root cause analysis process is performed consistent with VHA requirements.

Concur.

Target date for completion: 1/31/19

### Director Comments

The Minneapolis VA Health Care System will ensure that the Patient Safety Program follows the Patient Safety Handbook including for RCA processes to include: selections of appropriate team members who are not directly involved in the care of the patient; a review of the record and selection of appropriate interviewees; and a root cause/contributing factor for each RCA completed effective immediately. The VISN 23 Patient Safety Officer will be consulted on the facility's RCA process for improvement for the next three RCAs to ensure compliance.

# OIG Contact and Staff Acknowledgments

| | |
|---|---|
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