



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Deficiencies in Care
Coordination and Facility
Response to a Patient
Suicide at the Minneapolis
VA Health Care System
Minnesota



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of the then-Congressman Timothy Walz regarding the care coordination for a patient who died by suicide while admitted to an inpatient medicine unit at the Minneapolis VA Health Care System (facility), Minnesota.

The patient was in their sixties at the time of death by suicide in spring 2018.¹ Prior to the patient's 2017 transfer to one of the facility's community based outpatient clinics (CBOCs), the patient received care at another VA medical facility for more than 10 years. The facility CBOC primary care provider diagnosed the patient with major depression and history of substance use in remission. In spring 2018, the patient arrived in the facility's Emergency Department requesting help with withdrawal symptoms. The patient told the Emergency Department staff nurse about thoughts of suicide and homicide, and acknowledged having a gun at home.

The evaluating psychiatrist recommended inpatient admission for observation and treatment of depressive symptoms, suicidal ideation, living alone with ample access to means of suicide, mild cognitive impairment, and withdrawal symptoms. Due to a lack of available facility or community psychiatric beds, the psychiatrist recommended admission to a medical unit and noted that the patient did not require continuous monitoring.

The patient was admitted to an inpatient medical unit. The psychiatrist assessed the patient as being at heightened, but not imminent, risk for suicide. Later that day, two staff members who were completing consults (a dietician and a chaplain), documented the patient had suicidal thoughts. The psychiatrist noted depression and confusion, but the patient denied suicidal ideation and verbalized not wanting to die.

Approximately two hours before the patient was found to be missing from the unit, a registered nurse overheard the patient on the telephone giving away property and expressing feelings of impending death in the hospital but did not document or report the conversation to treating providers. The VA police received a call that a patient had attempted suicide and was pronounced dead following unsuccessful resuscitation attempts.

The OIG team found deficiencies in care coordination, internal review effectiveness and sufficiency, and Patient Safety Committee and Quality Management Council documentation. Care coordination deficiencies included failure of facility's Emergency Department staff to report the patient's suicidal ideation to the facility's Suicide Prevention Coordinator as required by the Veterans Health Administration (VHA).² Although the two consulting staff members and inpatient registered nurse referenced above completed required suicide prevention training, they

¹ The OIG uses the singular form of they in this instance for privacy purposes.

² VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017.

did not involve clinicians when the patient verbalized suicidal thoughts and warning signs, as advised in training. Two of the three staff documented the patient's suicidal thoughts and warning signs in consult results notes, but the OIG did not find documentation that indicated the inpatient medicine resident reviewed or acted on the consult results.³ According to the facility's Assistant Chief of Medicine, medical responsibility for the patient transferred to the oncoming attending physician when the night float resident's shift ended; therefore, the responsible provider may not have been alerted to the consult results notes. These care coordination deficiencies may have resulted in a failure to provide adequate mental health assessment and monitoring of the patient.

The facility's root cause analysis team did not interview staff members with knowledge of the patient's death, which may have contributed to the team's insufficient information to identify additional critical root causes. As part of the internal review process, the team identified many lessons learned for which VHA does not require action items. However, VHA does not provide written guidance to advise on the identification of lessons learned, related action expectations, and how to distinguish lessons learned from root causes. The absence of formal guidance may have contributed to the team's failure to identify actions that may be critical to the prevention of adverse patient events.

Additionally, facility leaders did not make an institutional disclosure to the patient's next of kin.⁴ The OIG identified failures of staff to adhere to required suicide prevention training guidance and consult follow-up. Given the OIG-identified deficits, facility leaders should consider an institutional disclosure.

The OIG team found that the Patient Safety Committee and Quality Management Council meeting minutes did not document deliberations or track actions to resolution, as required by facility and VHA policy.⁵ These deficiencies may result in gaps in performance improvement and quality assurance processes intended to prevent further adverse events. Further, the Patient

³ VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016.

⁴ VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients*, October 2, 2012 (corrected copy October 12, 2012). An institutional disclosure is a formal process for facility leaders and clinicians to inform the patient or patient's personal representative that an adverse event occurred and includes specific information about the patient's rights and recourse. This handbook was in effect at the time of the events discussed in the report; it was rescinded and replaced by VHA Directive 1004.08, October 31, 2018. The two policies contain the same or similar language defining clinical and institutional disclosures.

⁵ Minneapolis VA Health Care System Policy PI-24A, *Quality Management Council*, December 1, 2017. The facility requires the Patient Safety Committee to analyze patient safety issues, track root cause analyses and action items, and disseminate lessons learned. The Patient Safety Committee members included the Patient Safety Manager and a Primary Care & Specialty Medicine Service Line physician as co-chairs and representatives from select service lines, unions, and departments.

Safety Committee failed to disseminate lessons learned timely and accurately, as required by VHA, which may result in missed opportunities to prevent adverse patient outcomes.

Identified pharmacy process concerns will be reviewed in a separate inspection and will not be discussed in this report.

The OIG made one recommendation to the Under Secretary for Health related to the establishment of written guidance for root cause analysis teams regarding lessons learned.⁶

The OIG made six recommendations to the Facility Director related to Emergency Department staff's notification to the Suicide Prevention Coordinator when a patient presents with suicidal ideation, review of the patient's final episode of care and consideration of an institutional disclosure, and consultation with the appropriate Human Resources and General Counsel Offices to determine whether personnel actions are warranted, action on inpatient consult results, strengthening the root cause analysis process, and improving meeting minutes for the Patient Safety Committee and Quality Management Council.

Comments

The Executive in Charge, and the Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans. (See appendixes B-D for the Executive in Charge and Directors' comments.) The OIG considers all recommendations open and will follow up on the planned and recently implemented actions to ensure that they have been effective and sustained.



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⁶ The recommendation directed to the Under Secretary for Health was submitted to the Executive in Charge who has the authority to perform the functions and duties of the Under Secretary for Health.

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Abbreviations

CBOC	community based outpatient clinic
OIG	Office of Inspector General
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the request of the then-Congressman Timothy Walz regarding the care coordination for a patient who died by suicide while admitted to an inpatient medicine unit at the Minneapolis VA Health Care System (facility), Minnesota.

Background

The facility is part of Veterans Integrated Service Network (VISN) 23 and includes thirteen VA community clinics in both Minnesota and Wisconsin.⁷ VA classifies the medical center as a Level 1a–High-Complexity facility.⁸ The facility provides primary, specialty, mental and behavioral health, extended care, and rehabilitative care. From October 1, 2017, through September 30, 2018, the facility served 102,584 patients and had a total of 309 hospital operating beds, including 229 inpatient beds, and 80 community living center beds. The facility has professional and technical education affiliations with 63 universities and colleges, including the University of Minnesota Schools of Medicine and Dentistry, to provide health training in 36 programs.

Prior OIG Reports

In the 2018 report, *Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide*, the OIG found facility deficiencies in suicide prevention training and the root cause analysis process.⁹ The OIG made recommendations regarding documentation of lethality, Suicide Awareness Prevention Committee documentation requirements, and strengthening the root cause analysis process to comply with Veterans Health Administration (VHA) requirements. The OIG determined that the Patient Safety Manager included two individuals on the root cause analysis team who were directly involved in the event under review. Additionally, the OIG found that the root cause analysis team conducted two interviews and failed to interview several

⁷ The community based outpatient clinic locations are Hibbing, St. James, Mankato, Maplewood, Rochester, Ramsey, Albert Lea, Shakopee, and Ely, Minnesota, as well as Rice Lake, Hayward, Superior, and Chippewa Falls, Wisconsin.

⁸ The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most administratively complex. Level 3 facilities are the least complex. VHA Office of Productivity, Efficiency and Staffing, <http://opes.vssc.med.va.gov/Pages/Facility-Complexity-Model.aspx>. (The website was accessed June 11, 2019, and is an internal VA website not publicly accessible.)

⁹ VA Office of Inspector General, *Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide, Minneapolis VA Health Care System*, Minnesota, Report No. 18-02875-305, September 25, 2018.

clinicians with direct knowledge of the patient's inpatient and outpatient mental health services. Further, the root cause analysis team did not identify a root cause for the suicide. As of August 2019, all recommendations were closed.¹⁰

In the 2018, *Comprehensive Healthcare Inspection Program Review of the Minneapolis VA Health Care System*, the OIG identified deficiencies in committee meeting minutes and recommended monitoring the accuracy of action status and tracking of actions to closure in Executive Leadership Board and Peer Review Committee meeting minutes.¹¹ This recommendation was closed in June 2018.

Request for Review and Related Concerns

On October 23, 2018, the OIG received a request specifically focused on care coordination from then-Congressman Timothy Walz to review a patient's suicide. On November 11, 2018, the OIG requested additional information from the facility. The Office of Healthcare Inspections Hotline Work Group reviewed the received information and determined that further inspection of the internal review's identified lessons learned, and the effectiveness and sufficiency of corrective actions, was warranted. The Office of Healthcare Inspections accepted the hotline on January 3, 2019.

During the review, the OIG inspection team identified additional concerns related to Patient Safety Committee and Quality Management Council documentation and pharmacy processes. The documentation concerns are addressed in this report. The pharmacy processes (see details discussed in the patient case summary in appendix A) will be reviewed in a separate inspection and will not be discussed in this report.

Scope and Methodology

The OIG initiated the inspection in January 2019 and conducted a site visit from February 11–13, 2019.

The OIG team reviewed VHA directives and handbooks, National Center for Patient Safety guidelines, facility policies and procedures in effect in spring 2018 related to patient safety, quality management, and root cause analysis.

The OIG team reviewed the patient's electronic health record from summer 2017 through spring 2018. The OIG team interviewed the VHA Executive Director of the Suicide Prevention Program, a National Center for Patient Safety Analysis Officer, the VISN 23 Patient Safety

¹⁰ There was a change in the facility Patient Safety Manager position on November 1, 2018. The new Patient Safety Manager provided the documentation to support closure of the recommendations.

¹¹ VA Office of Inspector General, [*Comprehensive Healthcare Inspection Program Review of the Minneapolis VA Health Care System*](#), Minneapolis, Minnesota, January 11, 2018.

Officer, former and current facility leaders and managers, facility staff including a chaplain, a nurse, the Suicide Prevention Coordinator and suicide prevention case managers, psychiatry and pharmacy staff, and patient safety staff.

The OIG team reviewed suicide prevention training records from May 7, 2017, through September 30, 2018, for 33 clinicians including the 19 staff who engaged in direct care of the patient and an additional 14 staff employed on the inpatient medical unit as of June 2019.¹² The OIG team also reviewed Patient Safety Committee meeting minutes from May 1, 2018, through January 8, 2019, and Quality Management Council meeting minutes from May 17, 2018, through December 20, 2018.

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.

¹² The suicide prevention requirement was mandated in the VA Deputy Under Secretary for Health for Operations and Management, Memorandum—*Suicide Awareness Training*, April 11, 2017. The facility's first training occurred on May 7, 2017.

Patient Case Summary

The patient was in their sixties at the time of death by suicide in spring 2018.¹³ The patient used a central nervous stimulant for more than 30 years. Starting in 2006, the patient received mental health treatment at another VA medical center's community based outpatient clinic (CBOC). The patient established sobriety and mood stability for over 10 years through treatment including a combination of an antidepressant and an antipsychotic medication. In 2017, the patient transferred care to one of the facility's CBOCs. The primary care provider diagnosed the patient with major depression and history of substance use in remission. For additional patient case summary details related to pre-spring 2018, see appendix A.

On a day in spring 2018 (day 1), the patient's public health nurse informed the facility CBOC team that the patient had been taking leftover medication (benzodiazepine 1) and had run out.¹⁴ The nurse described the patient as "a little unsteady" and reported that the patient had "a rough weekend." The CBOC nurse called the patient who denied suicidal ideations although reported feeling more depressed. The patient agreed to come in the following day. On day 2, the patient presented to the CBOC. The primary care physician documented that the patient abruptly discontinued benzodiazepine 1 one week prior and had been trying to decrease use of opioid medication 1. The patient described dizziness, nausea, vomiting, and visual hallucinations but denied seizure activity. The patient verbalized a desire to stop taking all narcotic medications. The physician urged the patient to go directly to the facility's Emergency Department, but the patient declined and chose to go to a non-VA Emergency Department instead. The non-VA Emergency Department provided intravenous fluids and discharged the patient home. On day 3, following a fall, an ambulance transported the patient to a non-VA Emergency Department where the patient was treated with opioid medication and intravenous fluids, and discharged to home. The patient called the CBOC on day 4 requesting help with [opiate](#) and benzodiazepine withdrawal symptoms. The patient agreed to go to the facility Emergency Department and the CBOC nurse called ahead to provide communication regarding the transfer of care.

When the patient arrived in the Emergency Department on day 4, the triage nurse described the patient as disoriented and reported that the patient denied thoughts of self-harm or harming others. However, the patient told the Emergency Department staff nurse about thoughts of suicide and homicide, and acknowledged having a gun at home. The patient told the Emergency Department evaluating psychiatrist that the patient would "definitely end it," if "discharged home tonight and go into opiate WD [withdrawal]." The patient reported having a loaded gun and "a suitcase" filled with "old medications" at home. The evaluating psychiatrist

¹³ The OIG uses the singular form of they in this instance for privacy purposes.

¹⁴ The patient had a public health nurse who made home visits regularly to set up the patient's medication and monitor the patient. Mayo Clinic, *Benzodiazepines*. Benzodiazepines are central nervous system depressants, which effectively slow down the nervous system. This class of medication can be used to treat symptoms of anxiety.

recommended inpatient admission for observation and treatment of depressive symptoms, suicidal ideation, living alone with ample access to means of suicide, mild [cognitive impairment](#), and withdrawal symptoms. Due to a lack of available facility or community psychiatric beds, the psychiatrist recommended admission to a medical unit and stated, “[n]o need for 1:1 sitter,” because the patient professed being able to remain safe on a medical unit and agreed to alert staff to any thoughts of suicide or self-harm.

On day 5, the patient was admitted to an inpatient medical unit. The inpatient medicine resident noted that the patient was intermittently agitated and stated, “I want to die.” The resident prescribed a medication for agitation and [anxiety](#). Later that morning, the patient told the dietician, “I wish that someone could give me a dose of [morphine](#) so I could die.”¹⁵ The patient also told the chaplain about the wish for morphine to die, as well as feelings of guilt and being “unforgiveable.”¹⁶ The following morning, the resident documented that the patient “feels much better” but continued to express suicidal thoughts. Later that day, a nurse documented that the patient endorsed feeling depressed but denied suicidal ideation.

On day 7, the psychiatrist noted the patient’s depression and confusion, but the patient denied suicidal ideation and verbalized not wanting to die. The patient was found to have “significant” cognitive impairment, and the patient expressed a desire to go to a nursing home at discharge. The psychiatrist assessed the patient as being at heightened, but not imminent, risk for suicide, and did “not see need” for the patient’s transfer to an inpatient psychiatric unit but would re-assess once discharge options were determined. The psychiatrist deferred completion of a safety plan until the patient was ready for discharge. That evening, the chaplain documented that the patient thought “[the patient] may die soon.”

On day 8, the occupational therapist assessed the patient as having mild to moderate cognitive decline and recommended an assisted living facility placement at discharge. Mid-morning, an inpatient nurse overheard the patient on the phone telling someone that the patient was going to die in the hospital and “I want you to have the seven acres for all the help you have given me.” The patient was not in the hospital room approximately two hours later, and the nurse did not find the patient during a search of the unit. The nurse had the patient paged overhead, but the patient did not return. Forty-five minutes later, the nurse contacted the Assistant Nurse Manager, who then informed the VA police that the patient was missing. Approximately 30 minutes later, the VA police received a call that a patient attempted suicide. Emergency responders provided [cardiopulmonary resuscitation](#) before the patient was taken to a non-VA Emergency Department, where the patient was pronounced dead.

¹⁵ The dietician no longer works at the facility.

¹⁶ The chaplain no longer works at the facility.

Inspection Results

1. Care Coordination Deficiencies

Emergency Department Coordination with Suicide Prevention

VHA requires that Emergency Department staff assess all patients who present to the Emergency Department for suicide risk and inform the facility Suicide Prevention Coordinator of any patient who expresses suicidal ideation upon assessment.¹⁷ Upon presenting to the Emergency Department, the patient expressed suicidal ideation to a registered nurse and a psychiatrist. The psychiatrist completed a suicide risk assessment. However, the OIG did not find evidence that staff informed the facility Suicide Prevention Coordinator that the patient expressed suicidal ideation, as required by VHA. Facility staff's failure to inform the Suicide Prevention Coordinator of the patient's suicidal ideation may have contributed to less intensive ongoing evaluation and monitoring of the patient's suicidal risk.

Suicide Prevention

In April 2017, VHA required mandatory annual suicide prevention training for all clinical and non-clinical VHA employees.¹⁸ VHA requires newly hired clinicians to complete a web-based course entitled *Suicide Risk Management Training for Clinicians*, followed by an annual refresher course.¹⁹ Non-clinical employees are required to complete an in-person, S.A.V.E. training, led by the suicide prevention coordinator, within the first 90 days of employment and a web-based refresher course annually thereafter.²⁰

S.A.V.E. training objectives include learning how to identify a patient at risk of suicide and appropriate actions staff should take when a patient is at risk for suicide. Employees learn that

¹⁷ VHA Directive 1101.05(2). *Emergency Medicine*. September 2, 2016, amended March 7, 2017.

¹⁸ VA Deputy Under Secretary for Health for Operations and Management, Memorandum - *Suicide Awareness Training*, April 11, 2017. For the purposes of the suicide prevention training requirement, clinical staff include physicians, psychologists, dentists, registered nurses, physician assistants, pharmacists, social workers, case managers, and vet center counselors. Non-clinical staff include food service workers, registration clerks, volunteers, police, chaplains, and dieticians.

¹⁹ VA Talent Management System, <https://www.tms.va.gov/SecureAuth35/>. (The website was accessed on April 1, 2019.) VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Employees*, December 22, 2017. The directive equates "clinician" 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."

²⁰ The S.A.V.E. training is Signs of suicidal thinking should be recognized, Asking about suicide, Validating feelings, Encouraging help, and Expediting treatment. VHA, Suicide Prevention Resource Center, <http://www.sprc.org/resources-programs/operation-save-va-suicide-prevention-gatekeeper-training>. (The website was accessed on April 1, 2019.) VHA Directive 1071; VA Deputy Under Secretary for Health for Operations and Management, Memorandum - *Suicide Awareness Training*.

many individuals who attempt or die by suicide exhibit warning signs and that when a patient talks about suicide, it provides employees the opportunity to intervene. Warning signs include feelings of hopelessness, looking for ways to die, and talking about death, dying, or suicide. S.A.V.E. training includes that if an employee recognizes that a patient is at risk for suicide, they should not leave the patient alone and should seek help by getting a clinician involved.

Suicide Prevention Training

The OIG found 83 percent compliance with suicide prevention training requirements from May 7, 2017, through September 30, 2018, and 100 percent compliance from October 1, 2017, through September 30, 2018. The OIG confirmed that both the dietician and chaplain who assessed the patient completed required S.A.V.E. training. Further, all nursing staff who provided care to the patient completed the required suicide prevention training. Although the dietician, chaplain, and registered nurse completed the required training, they did not involve a clinician when the patient expressed a desire to die and talked about ways to die.

Coordination of Care

In 2016, VHA established a standardized consult process to ensure “timely and appropriate” provision of care. A requesting clinician enters a clinical consult in the electronic health record, on behalf of a patient, to request the opinion, advice, or expertise of another healthcare provider regarding evaluation or management of a specific problem. The requesting clinician identifies the responsible provider on the consult. The responsible provider must ensure review of consult status and act on the results ensure timely care.²¹

In the early morning of day 5, the admitting inpatient medical unit registered nurse entered consults for nutrition and chaplain services with the inpatient medicine resident on the night float rotation as the responsible provider. Approximately two and a half hours later, the inpatient medicine resident documented the patient’s history and physical. According to the facility’s Assistant Chief of Medicine, medical responsibility for the patient transferred to the oncoming attending physician when the night float resident’s shift ended at 7:30 a.m. that day.

In the afternoon of day 5, a dietician documented that the patient “was not in an appropriate state for a nutrition assessment.” The patient responded to the dietician’s questions about nutrition by saying, “I came here to die” and “I wish that someone would give me a dose of morphine so I could die.” The dietician assessed the patient as not ready to learn because of “significant withdrawal and worsening depression.” Later that day, the patient expressed a desire to die to the chaplain, wanting the doctor to “give me a dose of morphine so that I can just go,” and expressed feeling “unforgivable.” On day 8, approximately two hours before the patient was found to be

²¹ VHA Directive 1232(1), *Consult Processes and Procedures*, August 24, 2016, amended September 23, 2016.

missing from the unit, a registered nurse overheard the patient on the telephone giving away property and expressing feelings of impending death in the hospital.

The OIG team did not find evidence that the dietician, chaplain, or registered nurse involved other treatment team members when the patient made statements consistent with serious suicidal feelings. The dietician and chaplain completed consult notes; however, there was no electronic health record documentation or staff report that the dietician and chaplain involved a clinician in the care of the patient. Further, the OIG did not find subsequent documentation that indicated that the inpatient medicine resident reviewed the nutrition or chaplain consult status or acted on the consult results, as required by VHA.²² The registered nurse did not notify a clinical provider about the patient's statements that reflected suicidal ideation, and documented the patient's telephone conversation after the patient's death. The failure to involve treatment team members following the patient's suicidal statements or to follow up on the consult documentation resulted in missed opportunities for a clinical provider to further evaluate the patient's condition and provide treatment that may have prevented the patient's suicidal behavior.

2. Internal Review Effectiveness and Sufficiency

In 1999, the VA established the National Center for Patient Safety to facilitate a culture of safety and lead patient safety efforts throughout VHA. The goal of the National Center for Patient Safety is to reduce and prevent inadvertent adverse patient events as a consequence of medical care.²³ National Center for Patient Safety staff are subject matter experts who instruct and advise the field on "patient safety techniques, hands on patient care measures, data analysis, and outcomes research." A National Center for Patient Safety Program Manager is assigned to each VISN to provide scientifically sound and evidence-based guidance to the field.

The National Center for Patient Safety is responsible for the VHA National Patient Safety Improvement Handbook, which provides guidance on conducting root cause analyses. The root cause analysis process utilizes a focused review with a multidisciplinary team approach to identify system and process factors that contribute to healthcare-related adverse events.²⁴ An adverse event may warrant institutional disclosure, which is a formal process for facility leaders

²² VHA Directive 1232(1). The inpatient medicine resident was not available to be interviewed by the OIG team.

²³ VA Brochure, *National Center for Patient Safety Brochure*, 2016.

²⁴ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. VHA defines adverse events as harmful occurrences directly associated with facility care or services. This VHA Handbook is scheduled for recertification on or before the last working date of March 2016 and has not been recertified.

and clinicians to inform the patient or patient's personal representative that an adverse event occurred, and includes specific information about the patient's rights and recourse.²⁵

A credible root cause analysis must include participation by facility leadership, demonstrate internal consistency, and consider relevant literature. Individuals directly involved with the adverse event "need to be interviewed as part of the root cause analysis process and asked for suggestions about how to prevent the same or similar situations from happening again." The root cause analysis process should identify at least one root cause with associated action items and outcome measures. The root cause analysis may also identify additional contributing factors, referred to as lessons learned, that are not the most basic reason that an adverse event occurred and do not require associated action items.²⁶ National Center for Patient Safety does not provide written guidance to facilities regarding required follow-up on lessons learned through the root cause analysis process.²⁷

The OIG team determined that the Facility Director, in accordance with VHA and facility policies, established a root cause analysis team to identify system or process factors that may have contributed to the patient's death.²⁸ However, the OIG found that the root cause analysis team failed to conduct an effective fact-finding to determine root causes and corrective actions sufficiently.

Immediately upon notification of the patient's death, the former Patient Safety Manager and facility leaders identified root cause analysis team members, and the Facility Director signed the root cause analysis charter. In summer 2018, the root cause analysis team presented the findings to the Acting Facility Director and facility leaders addressed the identified issue.

The OIG team found that the root cause analysis team failed to conduct sufficient fact-finding by not interviewing individuals vital to the process including those directly involved in the patient's care and adverse event, as required by VHA.²⁹ Facility, VISN, and National Center for Patient Safety leaders told the OIG that they would expect the root cause analysis team to interview staff directly involved in the patient's care. Failure to interview staff directly involved in the patient's care may result in insufficient information to identify critical root causes.

²⁵ VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients*, October 2, 2012 (corrected copy October 12, 2012). This handbook was in effect at the time of the events discussed in the report; it was rescinded and replaced by VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. The two policies contain the same or similar language defining clinical and institutional disclosures.

²⁶ VHA Handbook 1050.01.

²⁷ VA National Center for Patient Safety, *RCA Step-By-Step Guide*, Rev. July 1, 2016.

²⁸ VHA Handbook 1050.01; Minneapolis VA Health Care System, PI-03B, *Patient Safety Program and Patient Incident Reporting*, January 30, 2017.

²⁹ VHA Handbook 1050.01.

National Center for Patient Safety provides no guidance to facilities regarding required follow-up on lessons learned through the root cause analysis process.³⁰ The National Center for Patient Safety Program Analysis Officer told the OIG team that facilities struggle with differentiating lessons learned from root causes and that some lessons learned may actually be root causes. The facility's Patient Safety Manager also noted that some of the identified lessons learned might potentially be root causes of the adverse event. Facility staff acknowledged a lack of clarity regarding expectations for actions to address lessons learned. In the absence of written guidance regarding the identification of lessons learned, how to distinguish lessons learned from root causes, and expected actions associated with lessons learned, a team might fail to recommend actions to mitigate risks due to the designation of an issue as a lesson learned rather than a root cause. Additionally, facility leaders did not make an institutional disclosure to the patient's next of kin.³¹ The OIG identified failures of staff to adhere to required suicide prevention training guidance and consult follow-up. Given the OIG-identified deficits, facility leaders should consider an institutional disclosure.

3. Patient Safety Committee and Quality Management Council Documentation Deficiencies

The facility requires the Patient Safety Committee to report to the Quality Management Council and analyze patient safety issues, track root cause analyses and action items, and disseminate lessons learned. The Quality Management Council reports to the Executive Leadership Board and provides oversight to the Patient Safety Program and monitors progress toward action plans.³² VHA requires that committee meeting minutes track issues to resolution.³³ Facility policy requires the Quality Management Council chairperson to ensure that the Patient Safety Committee records minutes include a summary of deliberations, identified actions, expected action completion dates, and completed actions.³⁴

In a review of Patient Safety Committee and Quality Management Council meeting minutes from May 2018 through January 2019, the OIG identified that the Patient Safety Committee minutes did not consistently include progress of action plans, completed actions or future

³⁰ VA National Center for Patient Safety, *RCA Step-By-Step Guide*, Rev. July 1, 2016.

³¹ VHA Handbook 1004.08; VHA Directive 1004.08, October 31, 2018.

³² Minneapolis VA Health Care System Policy PI-24A, *Quality Management Council*, December 1, 2017. The Patient Safety Committee members included the Patient Safety Manager and a Primary Care & Specialty Medicine Service Line Physician as co-chairs and representatives from select service lines, unions, and departments.

³³ VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. This VHA Handbook was scheduled for recertification on or before the last working date of August 2018 and has not been recertified.

³⁴ Minneapolis VA Health Care System Policy PI-24A, *Quality Management Council*, December 1, 2017.

actions, or a summary of deliberations, as required by VHA and facility policy.³⁵ Beginning in October 2018, Patient Safety Committee meeting minutes began to identify past due action items and track progress towards completion of past due action items. Quality Management Council meeting minutes, from May 2018 through January 2019, did not include progress of action plans or completed actions, as required by VHA and facility policy.³⁶ These deficiencies may result in gaps in performance improvement and quality assurance processes intended to prevent further adverse events.

Facility policy requires that the Patient Safety Committee “disseminate lessons learned” from root cause analyses. Staff told the OIG team that the Patient Safety Committee posted lessons learned on the facility’s Patient Safety SharePoint site that is accessible to all staff. The OIG found that 5 of 18 completed root cause analyses were posted on the Patient Safety SharePoint site.³⁷ Four of the five posted lessons learned were different from the corresponding final lessons learned submitted to the National Center for Patient Safety. The Patient Safety Committee’s failure to disseminate lessons learned timely and accurately may result in missed opportunities to prevent adverse patient outcomes.

Conclusion

The OIG team found deficiencies in care coordination, internal review effectiveness and sufficiency, and Patient Safety Committee and Quality Management Council documentation. Care coordination deficiencies included failure of the facility’s Emergency Department staff to report the patient’s suicidal ideation to the facility’s Suicide Prevention Coordinator, as required by VHA. Additionally, three staff members did not involve clinicians when the patient verbalized suicidal thoughts and warning signs. Further, the OIG did not find documentation that indicated that the inpatient medicine resident reviewed the nutrition or chaplain consult status or acted on the consult results, as required by VHA.³⁸ These care coordination deficiencies may have resulted in a failure to provide adequate mental health assessment and monitoring of the patient.

The facility’s internal review team did not interview staff members with knowledge of the event, which may have contributed to the team’s insufficient information to identify critical root causes sufficiently. The internal review team identified many lessons learned for which VHA does not require action items. Further, VHA does not provide written guidance on the identification of lessons learned, related action expectations, and how to distinguish lessons learned from root causes. The absence of formal guidance may have contributed to the team’s failure to identify

³⁵ VHA Directive 1026; Minneapolis VA Health Care System Policy PI-24A.

³⁶ VHA Directive 1026; Minneapolis VA Health Care System Policy PI-24A.

³⁷ The OIG reviewed facility root cause analyses during the period of October 1, 2017, through September 30, 2018.

³⁸ VHA Directive 1232(1).

actions that may be critical to the prevention of adverse patient events. Additionally, facility leaders did not make an institutional disclosure to the patient's next of kin. The OIG identified failures of staff to adhere to required suicide prevention training guidance and consult follow-up. Given the OIG-identified deficits, facility leaders should consider an institutional disclosure.

The OIG team found that the Patient Safety Committee and the Quality Management Council meeting minutes did not document deliberations or track actions to resolution, as required by VHA and facility policy. These deficiencies may result in gaps in performance improvement and quality assurance processes intended to prevent further adverse events. Further, the Patient Safety Committee failed to disseminate lessons learned timely and accurately, as required by VHA, which may result in missed opportunities to prevent adverse patient outcomes.

Recommendations 1–7

1. The Minneapolis VA Health Care System Director ensures that Emergency Department staff notify the facility Suicide Prevention Coordinator when a patient presents with suicidal ideation, as required by the Veterans Health Administration.
2. The Minneapolis VA Health Care System Director conducts a full review of the patient's final episode of care, including consults, and considers whether an institutional disclosure is warranted.
3. The Minneapolis VA Health Care System Director conducts a full review of the patient's final episode of care and consults with the appropriate Human Resources and General Counsel Offices to determine whether any personnel actions are warranted.
4. The Minneapolis VA Health Care System Director ensures that inpatient consult results are acted upon by the responsible provider or appropriate designee and monitors compliance.
5. The Minneapolis VA Health Care System Director strengthens processes in root cause analyses consistent with Veterans Health Administration requirements.
6. The Under Secretary for Health ensures that the Veterans Health Administration establishes written guidance for root cause analysis teams to identify lessons learned and expectations regarding related actions.³⁹
7. The Minneapolis VA Health Care System Director ensures that the Patient Safety Committee and Quality Management Council meeting minutes include deliberations and tracking of actions to resolution, as required by Veterans Health Administration and facility policy.

³⁹ The recommendation directed to the Under Secretary for Health was submitted to the Executive in Charge who has the authority to perform the functions and duties of the Under Secretary for Health.

Appendix A: Patient Case Summary

The patient was in their sixties at the time of death by suicide. After military discharge, the patient used a central nervous system stimulant for more than 30 years and established abstinence in 2006. The patient reported mood stability on a combination of an antidepressant and an antipsychotic medication for more than 10 years. In 2006, the patient established care with the VA after receiving non-VA mental health and substance use disorder treatment and was diagnosed with [major depressive disorder](#), recurrent, severe, and substance use remission. The patient completed a one-month VA domiciliary admission in 2007 and continued mental health treatment at a VA medical center CBOC.

In summer 2017, the patient transferred care to one of the facility's CBOCs. The primary care provider diagnosed the patient with major depression, and history of substance abuse, in remission. The psychiatrist continued the patient's six active medications for treatment of anxiety, [insomnia](#), chronic pain, depression, and stabilization of mood. Prior to this episode of care, the patient was prescribed medication for anxiety and insomnia, but that prescription was discontinued because the patient was also taking medication for sleep.

In fall 2017, the patient presented to a non-VA hospital Emergency Department with a complaint of new onset headaches for three days. Brain imaging revealed a 4-centimeter brain mass consistent with a [neoplasm](#) and the patient was directly admitted to the facility. During the admission medication reconciliation, the patient reported having "extra bottles" of benzodiazepine 1 and taking the medication at bedtime for anxiety and sleep despite having been told not to by a provider. The patient was discharged three days later, with a plan to return for tumor removal surgery approximately a month later.

Prior to the scheduled surgery, the patient's public health nurse contacted the CBOC primary care nurse with concerns about the patient's nonadherence with the prescribed medication regimen.⁴⁰ The public health nurse reported that the patient was not taking medication as prescribed and that the patient "is very calm in the mornings, but by evening, [the patient] is agitated; tells nurse and family that [the patient] sees bugs in [the] house again." The primary care nurse recommended that the public health nurse contact the neurosurgery team.

Ten days later, the patient was admitted for a [craniotomy](#) and [meningioma resection](#). The pathology report confirmed a meningioma diagnosis. During recovery, the patient exhibited impairments in balance, mobility, and completion of activities of daily living. The patient was admitted to acute inpatient rehabilitation four days after surgery. Approximately two weeks later, the interdisciplinary treatment team met with the patient's family members. The interdisciplinary

⁴⁰ The patient had a public health nurse who made home visits regularly to set up the patient's medication and monitor the patient.

treatment team described improvement in the patient's activities of daily living and ability to walk, and recommended 24-hour supervision, cessation of driving, and a family member to stay with the patient for a week to help with home equipment set-up and development of routines after discharge. The physician recommended that pain medications continue to be tapered on an outpatient basis. The patient repeatedly refused to stay with family members or to discharge to a supervised facility. The patient was discharged to home six days later, with instructions to follow up with primary care, the traumatic brain injury clinic, radiation oncology, neurosurgery, mental health, and with the home public health nurse.

The patient met with a psychiatrist for an intake evaluation a month later. During that visit, the patient described a "pretty good" mood and denied current suicidal ideation, though the patient continued to report insomnia and memory problems. The psychiatrist diagnosed the patient with [mild neurocognitive disorder](#); major depression; recurrent, moderate, [delusional disorder](#); and substance use disorder in sustained remission. The patient reluctantly agreed to discontinue benzodiazepine 2, increase the sleep medication, and continue the other medications, including sustained-release antidepressant 1 daily. At the patient's follow-up visit the patient admitted to continuing benzodiazepine 2 despite instructions to stop taking it, due to fears of worsening insomnia. The psychiatrist repeated the rationale for discontinuation and told the patient the benzodiazepine 2 would not be refilled. The patient again described a good mood and denied suicidal ideation. The psychiatrist planned to increase the sleep medication dosage, discontinue benzodiazepine 2, and continue other medications at prior doses. The last prescription for antidepressant 1 was a three-month supply ordered in late 2017, but it was discontinued by pharmacy 21 days later. Approximately a month later, neither the mental health nurse's progress note nor the medication reconciliation note included antidepressant 1. The patient did not attend the scheduled psychiatric follow-up in spring 2018.

Appendix B: Executive in Charge Memorandum

Department of Veterans Affairs Memorandum

Date: November 26, 2019

From: Executive in Charge, Office of the Under Secretary for Health (10N)

Subj: Healthcare Inspection—Deficiencies in Care Coordination and Facility Response to a Patient
Suicide at the Minneapolis VA Health Care System, Minnesota

To: Director, Office of Healthcare Inspections (54MH00)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. Thank you for the opportunity to review and comment on the Office Inspector General (OIG) draft report, Deficiencies in Care Coordination and Facility Response to a Patient Suicide at the Minneapolis VA Health Care System, Minnesota.
2. OIG assigned 7 recommendations to VHA. Recommendation 6 is assigned to VHA's Under Secretary for Health; and recommendations 1-5 and 7 are assigned to the Minneapolis VA Health Care System Director. I concur with OIG's recommendation 6 and provide the attached action plan.
3. If you have any questions, please email Karen Rasmussen, M.D., Director, GAO OIG Accountability Liaison Office at VHA10EGGOALAction@va.gov.

(Original signed by:)

Richard A. Stone, M.D.

Executive in Charge Response

Recommendation 6

The Under Secretary for Health ensures that Veterans Health Administration establishes written guidance for root causes analysis teams to identify lessons learned and expectations regarding related actions.

Concur.

Target date for completion: December 2019

Executive in Charge Comments

The VHA National Center for Patient Safety (NCPS) will develop written guidance defining lessons learned in the context of root cause analysis and the expectations for actions associated with lessons learned during a root cause analysis when identified. This guidance will be provided as a memorandum distributed to the Veterans Integrated Service Network (VISN) Network Leadership, VISN Patient Safety Officers, and the Facility Patient Safety Managers and made available on the NCPS intranet website under RCA Tools.⁴¹

OIG Comment

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

⁴¹ The NCPS intranet website is an internal VA website that is not accessible to the public.

Appendix C: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 6, 2019

From: Director, VA Midwest Health Care Network, Eagan, Minnesota (VISN 23)

Subj: Healthcare Inspection—Deficiencies in Care Coordination and Facility Response to a Patient
Suicide at the Minneapolis VA Health Care System, Minnesota

To: Executive in Charge, Office of the Under Secretary for Health (10N)

1. I have reviewed and concur with the findings and recommendations in the report of the Healthcare Inspection- Deficiencies in Care Coordination and Facility Response to a Patient Suicide at the Minneapolis VA Health Care System, Minnesota.
2. Corrective action plans have been established with planned completion dates, as detailed in the attached report.

(Original signed by:)

Robert P. McDivitt, FACHE

Network Director

Appendix D: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: November 5, 2019

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

Subj: Healthcare Inspection—Deficiencies in Care Coordination and Facility Response to a Patient
Suicide at the Minneapolis VA Health Care System, Minnesota

To: Director, VA Midwest Health Care Network, Eagan, Minnesota (10N23)

1. We are saddened by the loss of a fellow Veteran and have extended our deepest condolences to the Veteran's family. Suicide Prevention is the VA's number one clinical priority and this tragic event has greatly impacted the family and the staff at the Minneapolis VA Health Care System.
2. I have read the DRAFT Healthcare Inspection Report and concur with the findings. Attached are the Director's Comments in response to each recommendation set forth by the OIG.

(Original signed by:)

Patrick J. Kelly, FACHE
Director, Minneapolis VA Health Care System

Facility Director Response

Recommendation 1

The Minneapolis VA Health Care System Director ensures that Emergency Department staff notify the facility Suicide Prevention Coordinator when a patient presents with suicidal ideation, as required by Veterans Health Administration.

Concur.

Target date for completion: 31 March 2020

Director Comments

Process implemented since the event: Suicide Prevention Coordinator is currently notified of Veterans seen in the Emergency Department (ED) who express suicidal ideation the following ways:

- A Suicide Behavior and Overdose Report (SBOR) is completed in the ED.
- Through the Suicide Prevention in the Emergency Department (SPED) process when a Veteran is not admitted.

Other Actions:

- Suicide Program Manager hired for facility-wide oversight.
- Suicide Prevention Committee re-designed to be more interdisciplinary with facility-wide representation.

Future process in development: A quick order set will be automatically placed based off an affirmative response to suicidal ideation in the ED Registered Nurse (RN) Triage note. This order will notify the Suicide Prevention Coordinator and Suicide Prevention Team. This quick order set was implemented on October 28, 2019.

Auditing Plan: Suicide Prevention Program manager will monitor this process monthly. This will occur by running a report from the ED that identifies patients with suicidal ideation and a review of the veteran's chart, for 3 consecutive months. Results will be reported and monitored through the Suicide Prevention Committee.

Recommendation 2

The Minneapolis VA Health Care System Director conducts a full review of the patient's final episode of care, including consults, and considers whether an institutional disclosure is warranted.

Concur.

Target date for completion: Completed

Director Comments

Actions taken since the event:

- The Chief of Staff reached out to the Veteran's next of kin the day of the event to express our condolences and explain what happened. The Executive team met that day and directed that we conduct a quality management review, peer reviews for the providers involved and a Root Cause Analysis (RCA) to understand process issues in this case. Four peer reviews and a quality management review were completed, along with an RCA review. The facility addressed issues related to the environmental circumstances of the patient's suicide ahead of the established timeline.
- The Chief of Staff has conducted a comprehensive review of the documented course of care for this Veteran, including (1) review of the completed RCA; (2) review of the four completed peer reviews; (3) review of the quality assurance protected review; (4) the Veteran's electronic medical record; and (5) this OIG review. The Chief of Staff attempted to contact the family to conduct an institutional disclosure. They declined to speak with anyone from the VA.

OIG Comment

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

Recommendation 3

The Minneapolis VA Health Care System Director conducts a full review of the patient's final episode of care and consults with the appropriate Human Resources and General Counsel Offices to determine whether any personnel actions are warranted.

Concur.

Target date for completion: Completed

Director Comments

Actions taken since the event:

- The Director met with Facility leaders involved and determined that a quality management review and peer reviews would be conducted to address clinical concerns and an RCA conducted to address possible process issues. Four peer reviews and a quality management review were completed, along with an RCA review. The facility

addressed issues related to the environmental circumstances of the patient's suicide ahead of the established timeline. No personnel actions were taken as a result of these reviews.

- Based on this recommendation, the Director conducted a full review, using Just Culture algorithms and methodology and considering other available documents, to inform whether any personnel actions were warranted. The Director consulted with the Quality Management Officer, VISN 23 Human Resources staff and Regional Counsel and based on this review, has deemed that no personnel actions are warranted.

OIG Comment

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

Recommendation 4

The Minneapolis VA Health Care System Director ensure that inpatient consult results are acted upon by the responsible provider or appropriate designee and monitor compliance.

Concur.

Target date for completion: 1 July 2020

Director Comments

Actions taken since the event:

- Chaplain service met on 3 December 2018 to discuss with staff the actions they should take to safeguard inpatients when they express suicidal ideation. The Facility Suicide Prevention team held multiple training events for Chaplain service.
- Nutrition service held a staff training session on 11 March 2019. The Suicide Prevention team educated staff on actions to take when someone expresses suicidal ideation.
- Mental Health leadership reports daily the number of mental health consults for inpatients outside of the Mental Health unit and if they've expressed suicidal ideation. This is an opportunity for Facility leaders to hear about and discuss care coordination and any other issues related to these inpatients.

Future processes in development:

The Chief of Staff will clarify with clinical staff the expectation that there will be an immediate warm hand off from any consultant to the inpatient clinical care team if they become aware of increased suicidal ideation or other urgent medical issues. This warm hand off will be documented in the medical record. The Minneapolis VA Health Care System consult policy will be updated to add language reflecting this action. Compliance of this action will be monitored by

auditing the medical records of individuals determined to need admission to inpatient Mental Health for suicidal ideation or behavior who are admitted elsewhere in the Facility. The audit will be reviewing consultant notes. If there are notations of suicidal ideation, then the note should contain a) a warm hand off from the consultant to the inpatient care team and b) acted upon by the responsible provider. The audit will be reported to the Quality Management Council and then, in their minutes, to the Facility Executive Leadership Board.

Recommendation 5

The Minneapolis VA Health Care System Director strengthens processes in root cause analyses consistent with Veterans Health Administration requirements.

Concur.

Target date for completion: Completed

Director Comments

Minneapolis VAHCS previously received an OIG recommendation to strengthen our RCA processes. The following are the actions and evidence of compliance previously submitted and approved by OIG, which resulted in closure of the recommendation on May 13, 2019:⁴²

- A new Patient Safety Manager (PSM) was hired in November 2018.
- The VISN 23 Patient Safety Officer (PSO) was listed as a resource in the Charter for the RCA teams for three subsequent RCAs to ensure compliance with VHA and local policy requirements.
- The PSO and PSM consulted together to select appropriate team members, assure that the record was reviewed, select appropriate interviewees, and identify the root cause/contributing factors.
- An ongoing process implemented for RCA team member selection by the Facility Director and Chief of Staff. This is to ensure that the appropriate staff are assigned to these teams.

OIG Comment

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

⁴² VA Office of Inspector General, *Review of Mental Health Care Provided Prior to a Veteran's Death by Suicide, Minneapolis VA Health Care System*, Minnesota, Report No. 18-02875-305, September 25, 2018.

Recommendation 7

The Minneapolis VA Health Care System Director ensures that the Patient Safety Committee and Quality Management Council meeting minutes include deliberations and tracking of actions to resolution, as required by Veterans Health Administration and facility policy.

Concur.

Target date for completion: 1 May 2020

Director Comments

Minneapolis VAHCS developed a tool to track actions resulting from RCA root causes and lessons learned. In July of 2019, this tool became a monthly agenda item for the Patient Safety Committee to review and discuss. This discussion includes any barriers to the completion of actions/outcome measures. Moving forward, both the Patient Safety Committee and the Quality Management Council will use this tool to track open RCA actions and to ensure appropriate meeting deliberations. The Chairs will monitor monthly meeting minutes for three consecutive months to ensure these actions are appropriately documented in meeting minutes.

Glossary

anxiety. An expected part of life that involves worry or fear. For individuals with an anxiety disorder, it can get worse over time and can interfere with daily activities to include job performance, school work, and relationships.⁴³

cardiopulmonary resuscitation. A technique used in emergencies when someone has stopped breathing or the heart has stopped (for example, after a heart attack). Cardiopulmonary resuscitation keeps oxygen moving through the body until the heart rhythm or breathing can be restored.⁴⁴

craniotomy. A surgical procedure that removes a piece of bone from the skull to expose the brain. When the surgery is completed, the bone is replaced.⁴⁵

delusional disorder. A condition when an individual displays one or more delusions for one month or longer. A delusion is fixed beliefs that do not change, despite conflicting evidence presented to the person.⁴⁶

insomnia. A common sleep disorder that can make it hard to fall asleep, hard to stay asleep, or cause you to wake up too early and not be able to get back to sleep.⁴⁷

major depressive disorder. Is characterized by a period of at least two weeks with depressed mood and/or loss of pleasure or interest in activities. Symptoms, that are a marked change from one's prior functioning and not better explained by a medical condition, must be present much of the day nearly every day during the two-week period.⁴⁸

meningioma. A tumor that grows in the meninges, the thin layers of tissue that cover the brain and spinal cord.⁴⁹

⁴³ National Institute of Mental Health, *Anxiety*. <https://www.nimh.nih.gov/health/topics/anxiety-disorders/index.shtml>. (The website was accessed on May 22, 2019.)

⁴⁴ Mayo Clinic, *Cardiopulmonary Resuscitation*. <https://www.mayoclinic.org/first-aid/first-aid-cpr/basics/art-20056600>. (The website was accessed on May 2, 2019.)

⁴⁵ Johns Hopkins Medicine, *Craniotomy*. https://www.hopkinsmedicine.org/healthlibrary/test_procedures/neurological/craniotomy_92.p08767. (The website was accessed on March 25, 2019.)

⁴⁶ Psychology Today, *Delusional Disorder*., <https://www.psychologytoday.com/us/conditions/delusional-disorder>. (The website was accessed on May 23, 2019.)

⁴⁷ Mayo Clinic, *Insomnia*. Mayo Clinic, <https://www.mayoclinic.org/diseases-conditions/insomnia/symptoms-causes/syc-20355167>. (The website was accessed on May 22, 2019.)

⁴⁸ Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, American Psychiatric Association, *Major Depressive Disorder*, May 22, 2013 (print); September 24, 2014 (online). <https://doi.org/10.1176/appi.books.9780890425596.dsm04>. (The website was accessed on April 30, 2019.)

⁴⁹ National Cancer Institute, *Meningioma*. <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/meningioma>. (The website was accessed on March 25, 2019.)

mild cognitive impairment/neurocognitive disorder. An acquired cognitive decline in one or more cognitive domains such as complex attention, executive function, learning, memory, language, perceptual-motor, or social cognition.⁵⁰

morphine. An opioid pain medication that may become habit-forming with extended use.⁵¹

neoplasm. An abnormal growth of tissue that results from excessive cell division or from cells failing to die when they should. A neoplasm can be malignant (cancerous) or benign.⁵²

opiate. A medication or illegal drug that is derived from the opium poppy or that mimics the effect of a synthetic opiate that depress activity of the central nervous system, decrease pain, and induce sleep.⁵³

resection. A surgical procedure to remove tissue or part or all of an organ.⁵⁴

⁵⁰ John Grohol, *Symptoms of Minor Neurocognitive Disorder*, Psych Central, May 16, 2016. <https://psychcentral.com/disorders/symptoms-of-minor-neurocognitive-disorder/>. (The website was accessed May 23, 2019.)

⁵¹ Mayo Clinic, *Morphine*. <https://www.mayoclinic.org/drugs-supplements/morphine-oral-route/description/drg-20074216>. (The website was accessed on July 16, 2019.)

⁵² National Cancer Institute, *Neoplasm*. <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/neoplasm>. (The website was accessed on March 25, 2019.)

⁵³ William C. Shiel, *Medical Definition of Opiate*. <https://www.medicinenet.com/script/main/art.asp?articlekey=11771>. (The website was accessed on May 23, 2019.)

⁵⁴ National Cancer Institute, *Resection*. <https://www.cancer.gov/publications/dictionaries/cancer-terms/def/resection>. (The website was accessed on March 25, 2019.)

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