



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Patient Suicide on a
Locked Mental Health Unit
at the West Palm Beach
VA Medical Center
Florida



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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection, in response to a notification that a hospitalized patient died by suicide and a subsequent request from House Veterans Affairs Committee Chairman Mark Takano, to review the circumstances of the death. In early 2019, the patient used a garment as a lanyard that was knotted at the end and attached over the top of a corridor door while on a locked mental health unit (unit 3C) at the West Palm Beach VA Medical Center (facility), Florida.

Inpatient suicide is considered a “never event” and was the reason the OIG conducted an immediate inspection of the patient’s clinical care and the safety precautions in effect at the time of the death.¹ In accordance with OIG practices, the team also evaluated facility leaders’ knowledge of deficient conditions and actions taken, both prior to and after the event.

The OIG determined the patient received reasonable care while admitted to a locked inpatient mental health unit. The patient was appropriately screened for suicide risk, provided medication management, placed on close observation status, and had on-going assessments, interventions, and a discharge plan by physicians, nurses, and social workers. However, the OIG team noted that there was no single unifying treatment plan that conveyed the patient-specific plan of care with measurable goals and interventions as required by Veterans Health Administration (VHA) and The Joint Commission.

The facility did not meet VHA requirements for staffing an Interdisciplinary Safety Inspection Team or training staff regarding the Mental Health Environment of Care Checklist (MHEOCC). Only 44 percent of employees required to have MHEOCC training were in compliance due to some managers’ inattention to training requirements. Further, the Interdisciplinary Safety Inspection Team (and other responsible employees) failed to recognize the risk, and implement abatement strategies, of corridor doors as anchor points that could potentially be used by patients to hang themselves. The OIG also found a lack of oversight by both the VHA MHEOCC Work Group and Veterans Integrated Service Network 8 in that they did not identify inconsistencies in both ranking identified hazards or ensuring those hazards were abated.

Risk mitigation strategies used on unit 3C could not reliably ensure patient safety. While facility staff conducted 15-minute rounds for most patients, it was possible to have a span exceeding 25 minutes when a patient was not visually observed by a staff member. The patient safety and law enforcement cameras, which were required by the facility’s policy, had not been operational for at least three years due to inadequate network capabilities. Although a patient eloped from unit 3C nearly three months before the patient suicide, an internal review of the elopement did

¹ A “never event” is an adverse event that is clearly identifiable, results in death or significant disability, and is usually preventable.

not identify or address the non-operational law enforcement security cameras. Had the cameras been fixed and monitored as required by policy, it is possible that an employee may have seen the patient, who completed suicide in 2019, preparing for the event, and possibly been able to intervene. An after-the-fact recording from the law enforcement cameras could have potentially elicited important evidence that could be used to improve safety processes on unit 3C.

While unit 3C staffing was sufficient on the day of the patient's suicide, one of the nursing assistants assigned to conduct safety rounds also performed other duties during that time contrary to unit 3C protocol. The OIG team determined that the facility lacked a policy or clear expectations regarding 15-minute safety rounds, and staff did not have a consistent understanding of their duties with regard to the safety rounds.

Overall, the OIG found that facility leaders lacked awareness of patient safety requirements and related issues on unit 3C and appeared to accept inaccurate explanations for non-compliance and unsafe conditions. Leaders' failures to educate themselves about camera-related requirements on unit 3C, even after the December 2018 elopement and early 2019 suicide, represented a deflection of responsibility and failure to perform their duties. At the senior leadership level, the refrain of the doors not being a safety risk and door alarms not being required reflected a myopic view of the facility's responsibility to ensure patient safety.

While the OIG team determined the facility responded promptly to this adverse patient event and was in the process of implementing improvement actions, the team noted that facility leaders and managers only started to respond aggressively to long-standing deficient conditions after a sentinel event occurred.

The OIG made one recommendation to the Under Secretary for Health and one recommendation to the Veterans Integrated Service Network 8 Director related to MHEOCC and patient safety.²

The OIG made nine recommendations to the Facility Director related to environment of care, MHEOCC training, and risk mitigation. Recommendations also focused on facility policy regarding patient safety and law enforcement cameras on unit 3C; 15-minute safety rounding policy and staff training; and leadership responsibilities related to mental health, environment of care, and patient safety.

Comments

The Executive in Charge, Office of the Under Secretary for Health; Veterans Integrated Service Network Director; and Facility Director concurred with the recommendations and provided acceptable action plans (see appendixes A–C, pages 28–37 for the Under Secretary for Health

² 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.

and Directors' comments). The OIG considers all recommendations open and will follow up on the planned actions until they are completed.

A handwritten signature in black ink that reads "John D. Daigh, Jr., M.D." The signature is written in a cursive style.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
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Contents

Executive Summary	i
Abbreviations	v
Introduction	1
Scope and Methodology	5
Case Summary and Sequence of Events	6
Inspection Results	10
Issue 1. Clinical Care	10
Issue 2. Mental Health Environment of Care	12
Issue 3. Risk Mitigation	18
Issue 4. Unit 3C Staffing	21
Issue 5. Leadership Responsiveness	22
Conclusion	25
Recommendations 1–11	27
Appendix A: Under Secretary for Health Comments	29
Appendix B: VISN Director Comments	31
Appendix C: Facility Director Comments	33
OIG Contact and Staff Acknowledgments	39
Report Distribution	40

Abbreviations

EES	Employee Education Service
EHR	electronic health record
EOC	environment of care
ISIT	Interdisciplinary Safety Inspection Team
MHEOCC	Mental Health Environment of Care Checklist
NCPS	VHA National Center for Patient Safety
OIG	Office of Inspector General
PSAT	Patient Safety Assessment Tool
PTSD	posttraumatic stress disorder
TJC	The Joint Commission
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection, in response to a notification that a hospitalized patient died by suicide and a subsequent request from House Veterans Affairs Committee Chairman Mark Takano, to review the circumstances of the death. In early 2019, the patient used a garment as a lanyard that was knotted at the end and attached over the top of a corridor door while on a locked mental health unit at the West Palm Beach VA Medical Center (facility), Florida. The purpose of the inspection was to evaluate whether deficient conditions existed in select clinical, environmental, and administrative areas, and if so, whether those conditions impacted the patient’s hospital course and outcome.

Background

The facility provides comprehensive services including medical, surgical, and psychiatric care, and is classified as Level 1c–Mid-High Complexity.³ The facility operates six community-based outpatient clinics as well as a posttraumatic stress disorder (PTSD) outpatient clinic in Port Saint Lucie, Florida. In fiscal year 2018, the facility served 59,343 patients. The facility is part of Veterans Integrated Service Network (VISN) 8.

Unit 3C is a 25-bed high-intensity locked mental health care unit that has served at-risk patients for more than 24 years. According to facility policy, unit 3C is a “short-term stabilization program for Veterans in acute mental health distress.”⁴

Leadership Team

Some members of the leadership team were new to VA, and collectively, the team was relatively new to working together as a Pentad.⁵ The Facility Director came to Veterans Health Administration (VHA) from a large academic non-VA medical facility and started in the position in February 2017. The Associate Director came to VHA from the Department of Defense and assumed the position in December 2018. The Chief of Staff had been a hospitalist at the facility for several years prior to becoming the acting Chief of Staff in December 2017 and was

³ Veterans Health Administration’s Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3, with Level 1a facilities being the most complex and Level 3 facilities being the least complex.

⁴ Facility Memorandum 548-116-67, *Acute Inpatient Psychiatry*, April 15, 2016, states that the acute inpatient psychiatry unit (3C) is a short-term stabilization program for Veterans in acute mental health distress.

⁵ The senior leadership of VHA medical facilities is often defined as the “Quadrad” or “Pentad.” The leaders include the Director, Associate Director, Chief of Staff, Associate Director for Patient Care Services, and Assistant Director for Operations (if applicable).

appointed as permanent Chief of Staff in August 2018. The Associate Director for Patient Care Services had been in the role at the facility since December 2016 but had been in the same role at other VHA medical centers since 2012, and has worked in VHA for 19 years. The Assistant Director has been in the role at the facility since February 2017 and has worked in VHA for over 11 years.

Veteran Suicide

People attempt suicide for a variety of reasons. Common risk factors include mental disorders, stressful life events, financial problems, lack of social supports, and acute and chronic medical conditions.⁶ While risk factors and warning signs should be considered during any mental health assessment, “predicting with certainty whether any given individual will actually attempt suicide is difficult, if not impossible.”⁷

According to the Centers for Disease Control and Prevention, there were over 43,000 suicide deaths in 2016 in the U.S. in people ages 18 and older, resulting in a rate of 17.4 suicides per 100,000 population.⁸ Veterans accounted for 6,000 of those suicide deaths, resulting in a rate of 30.1 suicides per 100,000 veterans.⁹

While most suicides occur in the community, a surprising number occur in hospital settings. In 2017, The Joint Commission (TJC) noted that approximately 425 suicides within healthcare settings had been reported as sentinel events over the previous five years.¹⁰ For 2012 through 2017, VHA facilities reported 37 inpatient suicides, including two on locked mental health units, to the VHA National Center for Patient Safety (NCPS). Hanging is the method used in more than 70 percent of inpatient suicides, as independently reported by the Centers for Disease Control

⁶ Centers for Disease Control and Prevention, *Mental Health and Chronic Disease*, Issue Brief No. 2 (October 2012). <https://www.cdc.gov/workplacehealthpromotion/tools-resources/pdfs/issue-brief-no-2-mental-health-and-chronic-disease.pdf>. (The website was accessed on April 22, 2019.)

⁷ VA/Department of Defense Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide. Version 1.0 June 2013.

⁸ Centers for Disease Control and Prevention, *Leading Causes of Death Reports 1981–2016* <https://webappa.cdc.gov/sasweb/ncipc/leadcause.html>. (The website was accessed on April 16, 2019.); US Census Bureau. <https://www2.census.gov/programs-surveys/popest/datasets/2010-2016/national/asrh/nc-est2016-agesex-res.csv>. (The website was accessed on April 16, 2019.)

⁹ VA National Suicide Data Report 2005-2016; Office of Mental Health and Suicide Prevention, September 2018. https://www.mentalhealth.va.gov/docs/data-sheets/OMHSP_National_Suicide_Data_Report_2005-2016_508.pdf. (The website was accessed on April 5, 2019.); Deborah Stone et al., Vital Signs: Trends in State Suicide Rates – United States, 1999-2016 and Circumstances Contributing to Suicide – 27 States, 2015. *Centers for Disease Control and Prevention Morbidity and Mortality Weekly Report* 67, no. 22 (June 8, 2018) 618–624.

¹⁰ A sentinel event is a patient safety event that occurs to a patient and results in any of the following: death, permanent harm, or severe temporary harm and intervention required to sustain life. They are called sentinel because they signal the need for immediate investigation and response; The Joint Commission Resources. Special Report: Suicide Prevention in Health Care Settings. *Joint Commission Perspectives* 2017 Nov; 37(11):1 and 3–7.

and Prevention's National Violent Death Reporting System, TJC's Sentinel Event Database, and VHA's NCPS.¹¹

Patient suicide, or attempted suicide resulting in serious disability, while being cared for in a healthcare facility is a "never event." Never events, as defined by the Agency for Healthcare Research and Quality, are serious adverse events occurring in hospitals that are largely preventable and of concern to both the public and to healthcare providers.¹²

Mental Health Unit Safety and Security

Inpatient mental health unit staff care for some of the most seriously mentally ill and high-risk patients and special safety measures are required to prevent harm. TJC, the National Association of Psychiatric Health Systems, and VHA have issued guidelines outlining suicide prevention strategies that include requirements to eliminate or mitigate environmental conditions that could pose safety risks to patients.¹³ In addition, TJC and VA/Department of Defense have guidelines requiring clinical assessment, treatment, and management of patients at risk for suicide.¹⁴

The Mental Health Environment of Care Checklist (MHEOCC) was designed to help VHA facilities identify and address environmental risks for suicide and suicide attempts while patients are being treated on acute inpatient mental health units.¹⁵ It consists of criteria applicable to all rooms on the unit, as well as specific criteria for areas such as bedrooms, bathrooms, seclusion rooms, and staff work stations. The MHEOCC was implemented in 2007 and is associated with a substantial decrease in the rate of inpatient suicides.¹⁶ Since fiscal year 2014, the Patient Safety

¹¹ Scott Williams et al. Incidence and Method of Suicide in Hospitals in the United States; *The Joint Commission Journal on Quality and Patient Safety* 44, no. 11 (November 2018): 643–650.

¹² U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, Patient Safety Network, Never Events (last updated January 2019) <https://psnet.ahrq.gov/primers/primer/3/Never-Events>. (The website was accessed on April 24, 2019.)

¹³ The Joint Commission Manual E-dition *Behavioral Health Accreditation Requirements Environment of Care*, January 2019. <https://e-dition.jcrinc.com/MainContent.aspx>. (The website was accessed on May 16, 2019.); James M. Hunt and David M. Sine, *Behavioral Health Design Guide*, 7.4 ed. (Behavioral Health Facility Consulting, LLC, November 2018), 1–144.; Department of Veterans Affairs Office of Construction and Facilities Management, *Mental Health Facilities Design Guide*, (VA Construction and Facilities Management, December 2010, rev. December 1, 2017), 1–348.

¹⁴ The Joint Commission Manual E-dition *Behavioral Health Accreditation Requirements Care, Treatment and Services Standard Element of Performance*, January 2019. <https://e-dition.jcrinc.com/MainContent.aspx>. (The website was accessed on April 30, 2019.); 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, (Department of Veterans Affairs and Department of Defense, June 2013), 1–190.

¹⁵ In this report, the OIG uses the term "acute inpatient mental health unit" interchangeably with the term "locked mental health unit."

¹⁶ Bradley Watts et al. Sustained Effectiveness of the Mental Health Environment of Care Checklist to Decrease Inpatient Suicide. *Psychiatric Services* 68, no. 4 (April 1, 2017): 405–407.

Assessment Tool (PSAT) has been used to track the implementation and progress of abatement plans for reducing suicide hazards identified using the MHEOCC.¹⁷ When certain environmental hazards cannot be abated or abated timely, the facility must employ risk mitigation strategies to minimize the potential for harm from the identified hazard.

¹⁷ VHA Directive 1167, *Mental Health Environment of Care Checklist for Mental Health Units Treating Suicidal Patients*, May 12, 2017.

Scope and Methodology

The OIG initiated the inspection on March 19 and conducted a site visit March 21–22, 2019.

The OIG reviewed TJC standards, mental health architectural design guides, VHA documents including relevant directives, memoranda, guidelines, facility policies and procedures; staff training records; the patient’s electronic health record (EHR) with a focus on the early 2019 hospitalization; and MHEOCC inspection reports, environment of care (EOC) committee rounds and minutes, and patient observation rounds and checklists. The OIG also reviewed relevant photographs of the room and unit taken shortly after the incident, as well as the history of surveillance camera dysfunction on unit 3C. The OIG conducted a tour of the unit during the site visit.

The OIG interviewed facility leaders and staff including the Director, Associate Director, Assistant Director, Associate Director for Patient Care Services, Chief of Staff, Chief of Psychiatry, Chief of Police, Chief of Quality Management, Associate Chief of Quality Management, Suicide Prevention Coordinator, and Patient Safety Manager; the Chief Nurse for Mental Health programs, unit 3C nurse manager, and assistant nurse manager. The OIG also interviewed the unit 3C charge nurse and nursing staff on duty at the time of the suicide; the patient’s attending physician and social workers; and others with knowledge of the issues.

In this report, the OIG has generalized the narrative and case scenario, and has de-identified protected patient and quality assurance information.

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.

Case Summary and Sequence of Events

The patient, in their 30s, was last seen face-to-face by an outpatient VA psychiatrist in fall 2018.¹⁸ At that appointment, the patient denied thoughts of suicide and was prescribed a new antidepressant medication. In December 2018, after not appearing for psychiatric follow up, the patient was contacted by the psychiatrist and reported “doing fine” and was busy working. As the patient had not refilled medications since the fall appointment, the psychiatrist ordered a refill of medication, and at the patient’s request, made a referral to the PTSD program. The patient was evaluated by and accepted into the facility PTSD program in early 2019 and subsequently engaged in on-going outpatient PTSD care.

Two months later, non-VA police were called to the patient’s private residence because the patient’s spouse believed the patient to be suicidal. Based on a witness statement and evidence at the scene, the police transported the patient to the facility for involuntary examination under Florida’s Baker Act.¹⁹

On arrival to the facility’s emergency department, the patient was placed on one-to-one (1:1) observation status, and personal belongings were inventoried and removed for safety.²⁰ The emergency department physician assessed the patient and noted the patient was “visibly agitated and angry.” The patient reported being under personal stress, attributing it to a number of issues including the recent loss of a job and increasing marital discord. Once the patient was deemed medically stable and unwilling to be admitted voluntarily, the patient was admitted to unit 3C under the provisions of the Baker Act.

Upon arrival to unit 3C, the patient was placed on “close” observation status and remained on that level of safety observation throughout the hospital stay.²¹ The next morning (hospital day 1), the patient was seen by the inpatient psychiatrist. At that time, the patient denied all thought or intent of self-harm and stated the events of the previous evening were a misunderstanding. Another provider completed a full suicide risk assessment and deemed the patient to be at “high

¹⁸ The OIG uses the singular form of they in this instance for privacy purposes.

¹⁹ In Florida, certain clinicians and law enforcement officials can initiate the involuntary institutionalization and examination of an individual in a designated treatment facility, also known as a “Baker Act.” A person may be taken to a receiving facility for involuntary examination if there is a belief that, due to mental illness, the individual would be a harm to themselves or others. FLA. STAT. §§ 394.451–394.47892 (2018).

²⁰ Facility Memorandum 548-118-163, *Patient Observation Levels 1:1 and 2:1*, August 14, 2018. “A 1:1 patient observation requires one patient attendant to be within arm's length of the patient providing continuous and constant undistracted observation of that patient at all times including while the patient toilets, bathes, and sleeps.”

²¹ Facility Memorandum 548-118-163. “All 3C patients are to be checked every 15 minutes with the patient’s location and at least one behavior or activity i.e. [such as] asleep/awake documented in the Patient Attendant Checklist by the assigned unit staff member in real time. This is a standard practice on unit 3C.”

risk” of suicide.²² Further, due to the nature of events leading to the hospitalization, a “high risk for suicide” patient record flag was activated in the patient’s medical record.²³

Throughout the course of the hospital stay, the patient was cooperative with staff and increasingly social with select unit peers. The patient engaged in most unit activities, was sleeping well, and had a good appetite.

On hospital day 3, the patient agreed to accept prescribed antidepressant medication. In preparation for discharge, the patient made plans to stay with a family member in another state and was future-oriented and denied suicidal thoughts. Discharge was planned for the morning of hospital day 4.

On the morning of hospital day 4, an updated suicide risk assessment concluded that the patient was at “low risk” for suicide.²⁴ The patient had slept well overnight, denied suicidal thoughts or intent, and continued to be future-oriented regarding the plan to visit a family member. At the patient’s request, the patient was given the opportunity to sign-in to the unit as a “voluntary patient.”²⁵

In the afternoon, the inpatient psychiatrist assessed the patient as calm, pleasant, and cooperative. The patient again denied thoughts of suicide or intentions of self-harm. During this interview, the psychiatrist informed the patient that the team had not yet made contact with the spouse, and because the patient planned to go to their home before departing for a family member’s house, the team required contact to ensure a safe discharge. To this end, the patient was told that the discharge would be delayed until a member of the treatment team talked with the patient’s spouse. Immediately upon learning of the delayed discharge, the patient became significantly agitated, went to their room, and slammed the door. Shortly thereafter, the patient entered the day room, and according to documentation, started hitting the wall and their chest, and screaming “I wanna [*sic*] go home, you people are not helping me, nothing you're doing is

²² VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide. “High-acute risk patients include those with warning signs, serious thoughts of suicide, a plan and/or intent to engage in lethal self-directed violence, a recent suicide attempt, and/or those with prominent agitation, impulsivity or psychosis.”

²³ VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008, “The primary purpose of the High Risk for Suicide patient record flag is to communicate to VA staff that a veteran is at high risk for suicide and the presence of a flag should be considered when making treatment decisions;” According to VHA Directive 2010-053, a patient record flag alerts “VHA employees to patients whose behavior, medical status, or characteristics may pose an immediate threat either to that patient’s safety, the safety of other patients or employees, or may otherwise compromise the delivery of safe health care in the initial moments of the patient encounter” (emphasis in original text); VHA Handbook 1160.06, Section 11, paragraph (8)(c)1.

²⁴ VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide. “Low acute risk patients include those with recent suicidal ideation who have no specific plans or intent to engage in lethal self-directed violence and have no history or of active suicidal behavior.”

²⁵ Voluntary admission status means that a patient *chooses* to accept treatment on an inpatient unit. The Baker Act encourages the voluntary admission of persons for psychiatric care, but only when they are able to understand the decision and its consequences and are able to fully exercise their rights for themselves.

helping me. I'm not going to hurt anyone. I just want to see my kids and go back to [my family member's house].”

The patient declined medication to decrease the agitation but was able to sit with staff in the day area and expressed frustration regarding not being discharged. An hour later, the patient was noted to be calm and resting in the room. After another hour, the patient told the nursing staff, "I will be all right, I just wanted to be discharged today." Around this same time, the patient was observed occasionally using the phone, watching television in the day room, or napping on the bed. Documentation reflected that the patient denied suicidal ideation and was hopeful for discharge the following day.

The close observation safety rounding record reflected that the patient stayed in their room through the remainder of the afternoon. A nursing assistant documented seeing the patient in their room around 5:45 p.m., when the patient also reportedly declined dinner due to not being hungry. The nursing assistant reportedly did not enter the patient's room.

At approximately 6:00 p.m., a peer patient went to the patient's room to tell the patient there was a call on the public telephone in the day room. On reaching the room, the peer found the patient's door was closed and noted resistance on the door when trying to open it. A nursing assistant went to the room and pushed the door to gain access. The nursing assistant found the patient, unresponsive, on the ground with a garment tied around the neck that was attached to another garment tied in a knot and wedged over the top of the door. The nursing assistant called for the rapid response team at 6:01 p.m. A registered nurse arrived and the two freed the patient from the door and initiated cardiopulmonary resuscitation.²⁶

The code blue team was called at 6:06 p.m., the team arrived at 6:10 p.m., and transport to the emergency department was initiated at 6:16 p.m.²⁷ In the emergency department, rescue measures were continued with intravenous access attained at 6:25 p.m. and endotracheal intubation at 6:28 p.m., cardiopulmonary resuscitation continued, and resuscitative medications were serially administered without change in the patient's condition or effect.²⁸ Time of death was documented as 6:37 p.m. The code blue team leader notified the patient's next-of-kin shortly after the patient's death.

²⁶ Facility Memorandum 548-111-086 *Rapid Response Team*, December 3, 2018. “The Rapid Response Team will provide a rapid assessment, prompt intervention and management of patients with early signs of clinical deterioration and risk for cardiopulmonary arrest or other adverse events;” VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018. “Cardiopulmonary resuscitation is the use of therapeutic interventions, including Basic Life Support and Advanced Life Support, which are designed to restore spontaneous circulation following cardiac or respiratory arrest. Cardiopulmonary arrest is the loss of airway, breathing, or circulation necessary to maintain life that would result in death if not treated, often referred to as a code.”

²⁷ Facility Memorandum 548-111-81 *Code Blue Cardiopulmonary Resuscitation Response Team*, January 30, 2017. “The Medical Center Code Blue Team(s) will respond to all cardiopulmonary arrests within the medical center.”

²⁸ Endotracheal intubation is a medical procedure in which a tube is placed into the windpipe (trachea) to keep the airway open to give oxygen and to assist breathing.

As listed on the autopsy report, the patient's cause of death was "hanging," and the manner of death was "suicide."

Inspection Results

Issue 1. Clinical Care

Overall, the OIG team found that the patient received reasonable clinical assessment, treatment, and discharge planning services.

Suicide Risk Assessment

VHA and facility policies require in-depth evaluation and assessment of suicide risk at the time of a patient's admission to an inpatient mental health unit.²⁹ Additionally, at discharge, the patient must be re-evaluated for suicide risk.³⁰

Upon admission to unit 3C, the patient was screened and assessed according to guidelines through both a structured suicide risk assessment and an in-depth psychiatric evaluation. The patient was assessed as being high risk for suicide despite denial of suicidal thought or intent. This designation was appropriate at the time because of the patient's clinical history of PTSD and the reportedly chaotic events and spouse's assertion of the patient's suicidal behavior the previous evening.

Although guarded on admission, during hospitalization, the patient denied suicidal thoughts; had been visible, calm, and cooperative for three hospital days; engaged with the treatment team and was future-oriented; and had numerous protective factors against suicide.³¹ For these reasons, the patient was reasonably assessed as being at "low risk" for suicide on the morning of the death.

The clinical challenge for providers caring for patients at risk of suicide is when patients repeatedly and consistently deny all intent of self-harm and history of prior attempts.³² For example, clinicians had little information that indicated the patient would be at high risk for suicide, except for the Baker Act paperwork, because the patient denied history and intent. In fact, the patient had a "negative" screen for suicide based on responses obtained during the emergency department triage assessment for suicidality.³³

²⁹ VHA Handbook 1160.06, Section 10 a (2); Facility Memorandum 548-116-67.

³⁰ VHA Handbook 1160.06, Section 18 b (7); Facility Memorandum 548-116-67.

³¹ Protective factors are capacities, qualities, and environmental and personal resources that mitigate a person's drive to commit suicide. Examples of protective factors include religious beliefs, children in the home, or a future event that the person wishes to observe (such as a relative's marriage or graduation).

³² Robert Simon. Behavioral Risk Assessment of the Guarded Suicidal Patient. *Suicide and Life-Threatening Behavior* 38, no. 5 (October 2008): 517–522.

³³ The Columbia Lighthouse Project/Center for Suicide Risk Assessment. The Columbia Suicide Severity Rating Scale (C-SSRS) last revised February 2, 2018. The C-SSRS is a screening tool to triage patients and features questions that help determine whether an individual is at risk for suicide.

Inpatient Treatment

The patient's treatment while on unit 3C focused on mood stabilization and crisis intervention.³⁴ To achieve these goals, staff provided medication management and monitoring; regular safety checks; recreation and group therapy; and on-going physician, nursing, and social work assessments and interventions. The social work interventions, in preparation for sound discharge planning, focused on identifying the patient's current life stressors and strengthening the outpatient support network. Also, during the patient's hospitalization, close observation required that a qualified staff member document the patient's location and general behavior or activity every 15 minutes around the clock.

The patient's increased agitation on hospital day 4 (after learning of the delayed discharge) could have prompted clinicians to consider a higher level of observation such as 1:1. However, the clinical team's decision to leave the patient on close observation status was reasonable given the patient's presentation.

The OIG noted that although the EHR contained individual discipline treatment plans for the patient, there was no single unifying treatment plan that conveyed the patient-specific plan of care with measurable goals and interventions as required by VHA and TJC.³⁵

Discharge Plan

The patient's initial discharge plan was delayed so that staff could (1) notify the spouse of the plan, and (2) make arrangements for the patient to collect personal belongings at home prior to leaving for a family member's house in another state. It is common on an inpatient mental health unit to have delays in discharge. Plans for discharge can be complicated, and in this case, involved safety considerations for the patient's family. The patient's reaction on learning of the delayed discharge was within the normal range of reaction for a patient on a locked inpatient mental health unit. The patient was attended to through the course of the afternoon by multiple staff and appeared to have calmed considerably and continued to deny suicidal thoughts.

³⁴ The goal of mood stabilization is to curb the often uncomfortable and unpredictable swings of mood from which many mental health patients suffer. These mood swings can often be characterized as depressive episodes, anxious episodes, angry episodes and in some instances, episodes of intense elation; many patients are admitted to an inpatient mental health unit in moments of life crisis. The inpatient unit provides a venue in which many of life's stressors are removed from the immediate environment, allowing patients to therapeutically engage with staff and consider new and healthy coping strategies that may be employed in managing challenging life situations.

³⁵ VHA Handbook 1160.06, Section 11 c (7) and 7(a); The Joint Commission Manual E-edition, *Behavioral Health Accreditation Requirements Care, Treatment and Services Standard Element of Performance*, January 2019. <https://e-edition.jcrinc.com/MainContent.aspx>. (The website was accessed on April 30, 2019.)

Issue 2. Mental Health Environment of Care

A facility team conducted EOC risk assessment rounds on unit 3C every six months as required by VHA.³⁶ However, the OIG team determined that

- The facility did not meet VHA expectations related to the Interdisciplinary Safety Inspection Team (ISIT);
- MHEOCC training was insufficient;
- Inspection team members and other responsible staff did not consistently identify, report, and/or abate non-compliant or unsafe environmental conditions; and
- Oversight and follow-up did not consistently occur at the facility, VISN, and VHA levels.

Interdisciplinary Safety Inspection Team

The facility did not comply with VHA guidance related to ISIT requirements.³⁷ The goal of the ISIT team is to work together to understand and identify environmental hazards; develop appropriate abatement plans; track progress toward completion of corrective actions; and keep the Facility Director updated about progress in completing those actions.

The Facility Director failed to designate an ISIT to include the appropriate staff disciplines. VHA Directive 1167 states the ISIT conducts the inspection of the mental health unit using the MHEOCC. The ISIT should include the Suicide Prevention Coordinator, Patient Safety Manager, a facility Safety Officer, a pharmacist, the mental health inpatient nurse manager, other mental health nurse managers and employees, and representatives from engineering, environmental, and facilities management services.³⁸ The facility did not have a local MHEOCC policy and submitted their EOC policy when the OIG requested the MHEOCC policy. The facility ISIT also included representation from VA Police and Security Service as the Chief of Police and Associate Chief of Police are listed as members and a police officer has been part of every MHEOCC conducted at the facility. To increase the team's perceptual acuity, "more than half the team shall consist of clinical staff who do not regularly work on the unit being inspected and who are not accustomed to its surroundings."³⁹

By VHA policy, the ISIT is a mandatory subcommittee of the facility's EOC Committee. The ISIT membership should be recorded, as well as the date of last MHEOCC training, in the ISIT

³⁶ VHA Directive 1167.

³⁷ VHA Directive 1167.

³⁸ VHA Directive 1167, "A Facilities Management representative should be available to answer questions on the current construction standards used to build the unit (especially doors, windows, floors, fixtures, and ceilings, in accordance with the Mental Health Facilities Design Guide, as well as current VA codes, policy, and standards)."

³⁹ Perceptive acuity is the psychological and mental preparedness to "see around corners" and spot potentially significant anomalies, contradictions, and oddities in the external landscape before others do.

meeting minutes. The OIG team was told that neither an ISIT team nor a subcommittee had ever existed at the facility, and no minutes with the required elements had been recorded. While the facility did have an inspection team, the team was not comprised of the full range of appropriate disciplines and did not keep minutes.⁴⁰ The inspection group that reviewed unit 3C is referred to as the Mental Health EOC team in the remainder of this report.

MHEOCC Training

The OIG team found that facility leaders failed to ensure that Mental Health EOC team members and other responsible staff received MHEOCC training as required by VHA.⁴¹ VHA requires that MHEOCC training on environmental hazards should occur upon staff orientation and annually thereafter.⁴² Staff members who are both permanently assigned to the mental health unit or who have periodic responsibilities on the unit must be trained, including housekeepers, chaplains, outpatient providers, police officers, and members of the ISIT team.⁴³ VHA's Talent Management System, which is administered by the facility's Employee Education Service (EES), assigns on-line training modules to employees according to their duties and assignments.⁴⁴ The facility also used an NCPS slide presentation for training purposes, although reviewing the slides did not meet training requirements.

The OIG reviewed MHEOCC annual training history from January 2018 through March 2019 using current facility employee assignment data. The OIG's review of annual MHEOCC training records confirmed that not all relevant staff received the required training annually. According to VHA policy, 85 facility employees were required to have MHEOCC training because of their duties and assignments.

Although the MHEOCC has been used in VHA facilities since 2007 and MHEOCC training has been a long-term requirement, the OIG found that of the 85 employees

- EES identified 39 employees (46 percent) who, according to EES records, were required to receive annual MHEOCC training, and
- Thirty-seven employees (44 percent of employees required to have the MHEOCC training) completed the training in compliance with VHA Directive 1167.

EES also incorrectly reported that MHEOCC training was required 90 days from the employee's assignment date and not in orientation.

⁴⁰ The inspection team did not include a pharmacist or non-mental health unit nurse manager, and half the team was not staff from outside unit 3C.

⁴¹ VHA Directive 1167.

⁴² VHA Directive 1167.

⁴³ VHA Directive 1167.

⁴⁴ The required on-line MHEOCC modules are: Mental Health Environment of Care Checklist Training for Clinical Staff (VA 1290945), and Mental Health Environment of Care Checklist (MHEOCC) Training for Non-Clinical Staff (VA 1290950).

See Table 1 for the select groups of employees, the number of those employees who must receive annual MHEOCC training, the number that EES reported as requiring the training, and the number that received the training.

Table 1. Annual MHEOCC Training January 2018–March 2019

Staff Positions	Employees Requiring Training per VHA Directive 1167	Employees Requiring Training per EES	Employees who Completed Training
Unit 3C Nurses	24	16	15
Nursing Assistants	19	5	4
Mental Health Providers	8	7	7
Mental Health EOC Team	21	7	7
Suicide Prevention Staff	4	4	4
Social Workers	4	0	0
Housekeepers	5	0	0*
Total	85	39	37

Source: OIG analysis of EES clinical and non-clinical staff lists and staff training records.

**On March 19, 2019, the Environmental Management Service established a written facility safety procedure for all Environmental Management Service Housekeepers working on unit 3C. All five housekeeping staff received education on the safety procedure that included how to enter and exit the unit safely and when and how to secure linen hampers and cleaning carts.*

An example of the facility’s failure to comply with MHEOCC training expectations occurred in December 2018. Specifically, the Patient Safety Manager notified the Mental Health EOC team there would be an MHEOCC slide presentation on December 4, 2018, before the team conducted MHEOCC rounds on unit 3C. While 21 invitations were sent to team members and alternates, 11 members or alternates did not attend the training and did not participate in the unit 3C MHEOCC rounds. Two of the crucial members who did not participate included a pharmacist and a representative from the Suicide Prevention team. Lack of full participation limited the team’s perceptual acuity in identifying environmental hazards that represented a threat to suicidal patients.

In February 2019, the Patient Safety Manager requested that unit 3C staff, Mental Health EOC team members, and facility leadership meet to discuss action plan options that the facility should implement to provide the required MHEOCC training. The Patient Safety Manager told the OIG that because the turnout was lower than expected, the Patient Safety Manager met with each of the stakeholder leaders individually to discuss the training and expectations.

TJC’s expert panel on suicide risk emphasized the “critical importance of well-trained, vigilant, compassionate staff who rigorously follow procedures for protecting patients. Health care

organizations should focus as much on staff training and monitoring compliance with protocols as they do on detecting and correcting specific environmental hazards.”⁴⁵

Risk Assessment

Responsible managers and staff who conducted Mental Health EOC rounds over the past three years either did not identify that bedroom doors (into the corridors) presented risks because they could be used as anchor points for hanging or that actions were required to mitigate those risks. During interviews with the OIG, facility leaders, managers, and staff members repeatedly stated that the MHEOCC did not include corridor doors (beyond the doorknobs and other hardware) as a risk and reported that TJC and NCPS had not cited the facility for corridor door-related safety deficiencies. While the assertions related to TJC and NCPS were accurate, they did not obviate the need for ongoing and critical evaluation of the unit 3C environment and the requirement for risk mitigation.

The goal of proactive risk assessments is to identify potentially unsafe conditions before an adverse event occurs.⁴⁶ The NCPS created the MHEOCC to guide staff on common hazards and unsafe conditions found on mental health units associated with increased suicide risk.⁴⁷

According to VHA directive and the NCPS, the expectation for ISIT members and relevant staff is to consider potentially unsafe conditions and hazards beyond those listed in the MHEOCC.⁴⁸

Medical literature is replete with examples of how doors pose a substantial hazard on inpatient mental health units, specifically because they offer ligature points for hanging.⁴⁹ The NCPS slide presentation training specifically states that the most common hazard on mental health units are anchor points—protrusions that could support the weight of patients attempting to hang themselves. Because doors exiting to a corridor must meet Life Safety Code requirements to limit the transfer of smoke (in the event of a fire), safety doors as used on bathrooms would not be suitable.⁵⁰ As such, the hazard posed by corridor doors is more difficult to remediate, making

⁴⁵ The Joint Commission Resources. Special Report: Suicide Prevention in Health Care Settings. *Joint Commission Perspectives* 2017 Nov; 37(11):1 and 3–7.

⁴⁶ VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011, Section 5, paragraphs (a–f); Jeffrey Janofsky, Reducing Inpatient Suicide Risk: Using Human Factors Analysis to Improve Observation Practices, *Journal of the American Academy of Psychiatry and the Law* 37, no. 1 (March 2009): 15–24.

⁴⁷ Peter Mills et al. A Checklist to Identify Inpatient Suicide Hazards in Veterans Affairs Hospitals. *The Joint Commission Journal on Quality and Patient Safety* 36, no. 2 (February 2010): 87–93.

⁴⁸ VHA Directive 1167.

⁴⁹ Scott Williams et al. Incidence and Method of Suicide in Hospitals in the United States. *The Joint Commission Journal on Quality and Patient Safety* 44, no. 11 (November 2018): 643–650; Bradley Watts et al. Sustained Effectiveness of the Mental Health Environment of Care Checklist to Decrease Inpatient Suicide. *Psychiatric Services* 68, no. 4 (April 1, 2017): 405–407.

⁵⁰ MHEOCC requires interior bathroom doors to be ligature resistant, and VHA suggests the use of sloped or Styrofoam accordion doors as options.

risk mitigation essential.⁵¹ One mechanical option, which is not required, is over-the-door alarms. In these devices, door top sensors trigger an alarm in the nursing station when increased pressure (such as a ligature) is identified on the top of the door.

Recognizing that some doors could not be “ligature resistant,” VHA’s Assistant Deputy Under Secretary for Health for Clinical Operations sent a memorandum on March 21, 2012, to all VISN Directors and Chief Medical Officers about suicide prevention on inpatient mental health units.⁵² That memorandum stated, “It continues to be important to monitor for environmental hazards and be aware that any sheet, piece of clothing, towel, or similar item can be used for hanging or strangulation and that many permanent fixtures do provide anchor points despite our efforts to eliminate them. *Please consider the use of door alarms if you are not already using them* [OIG emphasis].” Further, the NCPS included the option of over-the-door alarms in a 2012 slide presentation specifically related to minimizing risk of self-harm on inpatient mental health units. Also, NCPS did not require the use of door top alarms, but suggested they be considered as a risk mitigation option.⁵³ NCPS’s subject matter expert on inpatient suicide told the OIG in April 2019, about 50 percent of VHA facilities’ mental health units used over-the-door alarms.

A Mental Health EOC inspection group conducting a thorough, proactive assessment according to established standards should have, at a minimum, questioned the safety of the corridor doors and evaluated the facility’s ability to implement door alarm systems as suggested by the Assistant Deputy Under Secretary for Health for Clinical Operations and the NCPS.

Another example of the Mental Health EOC team’s failure to identify unit 3C hazards involved a patient elopement in late 2018. The patient reportedly followed a housekeeper who exited the rear door of the unit.⁵⁴ The facility’s review identified several contributory factors, including a non-functional security camera and the rear door’s distant location from the nursing station, as well as a lack of training for clinical and non-clinical staff that work on the unit. Both conditions should have been identified during Mental Health EOC rounds. In addition, unit 3C staff did not identify security lapses and latent risks that allowed for the patient’s elopement.

Abatement Plans

The facility did not consistently abate identified hazards on unit 3C or complete the process to receive a waiver of abatement relative to deficiencies. Any environmental suicide hazard must be abated or appealed to the MHEOCC review board for review within six months of identifying

⁵¹ Joint Commission Resources. Special Report: Suicide Prevention in Health Care Settings. *Joint Commission Perspectives* 2017 Nov; 37(11):1 and 3–7.

⁵² VA Assistant Deputy Under Secretary for Health for Clinical Operations Memorandum, *Suicide Prevention*, March 21, 2012.

⁵³ TJC does not require use of over-the-door alarms or other mechanical devices to reduce the risk of a door top being used to fix a ligature, but TJC does comment on the availability of these items

⁵⁴ The patient was found in the parking lot by VA police and returned to the unit.

the hazard. If the MHEOCC review board finds that a specific hazard is unavoidable, a waiver will be granted, and the item will be considered closed.⁵⁵ This finding should be documented in the PSAT electronic record. If the review board finds that the hazard must be abated, the facility should develop an abatement plan within 48 hours and enter that plan into the PSAT.

OIG reviewed nine MHEOCCs submitted to the PSAT database from January 2015 through January 2019 to track the identification and abatement of seclusion room-related hazards. With respect to the seclusion room flooring, the OIG team found that the Mental Health EOC team inconsistently documented compliance with standards, alternating between “*Met*,” “*Not Met*,” and “*Partially Met*.” Further, the January 2015 MHEOCC report reflected “*floor has no cushioning and no plan to change the flooring*.” In January 2017, however, the floor section was documented as “*Met*,” with no evidence and/or documentation of remodeling. The OIG confirmed on a tour of unit 3C in March 2019 that the seclusion room did not have a cushioned floor as required.⁵⁶

MHEOCC criteria for seclusion rooms also require that blind spots (areas that cannot be visualized by staff from the doorway) be eliminated. When structural limitations preclude the elimination of blind spots, cameras are required in the room to allow for visualization of patients. The January 2015 MHEOCC report reflected that the standard for cameras was “*Met*.” However, the July 2015 MHEOCC showed, “*NA [not applicable] no cameras in the unit*,” in response to the visualization criteria question. The OIG found no documentation of abatement or a mitigation plan.⁵⁷ In March 2019, the OIG noted that there were no cameras in the seclusion room.

The OIG team found no evidence that waivers were requested or granted related to the seclusion room flooring or cameras. NCPS’s subject matter expert told the OIG that facilities cannot decide at the facility level “not to do something.”

Oversight and Follow-up

MHEOCC policy dictates that when an environmental safety concern is identified, a plan of corrective action is developed by the team leader and the unit nurse manager in conjunction with appropriate engineering and environmental services staff members. A copy of the Risk Assessment and Abatement Tracking spreadsheet is then forwarded to the Director’s Office monthly. The Facility Director will forward a copy of the spreadsheet each quarter to the VISN-level Patient Safety Officer, who will review the documentation for the VISN Director. The VISN Director will forward copies of all spreadsheets for the VISN to the VHA MHEOCC

⁵⁵ VHA Directive 1167.

⁵⁶ The unit 3C seclusion room has epoxy flooring, which is damage resistant. However, the MHEOCC requires a floor resistant to damage and of a material that provides cushioning in the event of a fall.

⁵⁷ The facility had installed a mirror in the seclusion area to help with patient visualization. The mirror was not an adequate mitigation strategy.

Work Group. The OIG did not find evidence that the review and oversight activities outlined above occurred for the period January to December 2018. Specifically

- The VISN Patient Safety Officer and the MHEOCC Work Group, which includes VHA Central Office Mental Health Program Offices and NCPS staff, did not identify inconsistencies in both ranking identified hazards or ensuring those hazards were abated, and⁵⁸
- The MHEOCC Work Group did not review every PSAT submission or abatement plan submitted; instead, the group relied on the facility to be vigilant and have a qualified inspection team (which is supposed to be the ISIT) to identify potential hazards.

Additionally, between January 2018 and March 2019, the VISN Patient Safety Officer had not responded to (or apparently questioned) the facility's PSAT submissions or abatement plans.

Issue 3. Risk Mitigation

Strategies employed by the facility to mitigate risks relative to corridor doors on unit 3C were minimal, lacking both insight and effectiveness.

According to the Behavioral Health Design Guide, “No built environment—no matter how well it is designed and constructed—can be relied upon as an absolute preventative measure. Staff awareness of their environment, the latent risks of that environment, and the behavioral characteristics risks and needs of the patients served in that environment are absolute necessities.”⁵⁹ Because systems or engineering fixes are not always 100 percent effective in eliminating suicide risk in this critical environment, patient supervision and additional safety measures are appropriate to mitigate risk.

TJC acknowledged in its 2017 Perspectives newsletter that mechanical devices to decrease the risk that the top of a door could be used to affix a ligature should not be required; however, the expert panel said that “organizations should note such doors on their environmental risk assessments and describe their mitigation strategies, such as appropriate rounding and monitoring by staff, requiring that doors be left open during certain hours, and so on.”⁶⁰ The OIG found no documentation on the semi-annual rounding sheets for 2015–2018 that the doors were identified as a risk or that mitigation strategies were needed.

⁵⁸ VHA Directive 1167.

⁵⁹ Behavioral Health Facility Consulting, LLC. Behavioral Health Design Guide (formerly: Design Guide for the Built Environment of Behavioral Health Facilities), Edition 7.4, November 2018.

⁶⁰ The Joint Commission Resources. Special Report: Suicide Prevention in Health Care Settings. *Joint Commission Perspectives* 2017 Nov; 37(11):1 and 3–7.

Patient Observation

The methods by which facility staff conducted and documented patient observation rounds could not reliably assure patient safety.

TJC requires supervision of patients on an inpatient mental health unit to prevent them from engaging in behavior that could be detrimental to their health.⁶¹ Despite this requirement, there are no uniform standards regarding how the supervision should be operationalized.⁶² Unit 3C had a baseline level of observation for all admitted patients that required they be checked every 15 minutes; this observation level did not require a physician's order. There were two higher (non-seclusion) levels of observation that required a specific physician order and were used for patients whose clinical presentations required closer monitoring than every 15 minutes.

Staff on unit 3C used a pre-printed form to document the 15-minute observation checks. The form spanned the 24-hour day, and the observer (nurse or nursing assistant) was to document the patient's location, one behavior or activity at that time (such as dining or sleeping), and then initial the form.

On the date the patient died, staff completed the 15-minute observation form and documented the patient was in the bedroom from 3:15 p.m. to the time of discovery shortly after 6:00 p.m. The OIG team noted

- The form did not reflect behavior or activity codes for this period. The nursing assistant who completed the form told the OIG of observing and speaking with the patient through the doorway, but not entering the room;
- Because of the structure of the form and the way rounds were conducted, nursing staff could observe the patient at any time during the 15-minute interval. Therefore, a patient could theoretically be observed at 1:35 p.m. and not again until close to 2:00 p.m.; and
- There was no process of oversight regarding the correct implementation, validity, or accuracy of the 15-minute check forms or process.

The OIG could not determine with certainty whether deficits in the 15-minute safety rounding process contributed to the patient's suicide. However, the team noted that the use of 15-minute safety rounds as a standalone mitigation strategy would be insufficient to ensure patient safety.

⁶¹ The Joint Commission Manual E-dition *Behavioral Health Accreditation Requirements Care, Treatment and Services Standard Element of Performance*, January 2019. <https://e-dition.jcrinc.com/MainContent.aspx>. (The website was accessed on May 1, 2019.)

⁶² All healthcare facilities with inpatient mental health units are required to safely supervise the patients under their care. Each facility, however, must decide *how* to operationalize this requirement and subsequently develop various levels of observation, criteria for each level, training for all staff, and a standard of care throughout their unit(s).

Specifically, patients can and do commit suicide while on 15-minute checks.⁶³ Death is usually from asphyxia and can occur in three to five minutes.⁶⁴

Safety and Security Cameras

Although cameras were present on unit 3C, they had reportedly been nonfunctional “for years.” Facility leaders and managers told the OIG that cameras “were not required” on unit 3C. However, according to facility policy, closed circuit television systems “will be utilized on [unit] 3C for purposes of enhancing patient safety and aiding law enforcement [VA Police] with the successful investigation and prosecution of crimes, when appropriate.”⁶⁵ Facility policy makes the following distinction:

Patient Safety cameras will be utilized in the following designated Treatment and Personal areas: The Isolation Room, the Dining Room, the Day Room, and the Outdoor Patio. Patient Safety CCTV [closed circuit television] camera images will be viewed at all times that the areas are in use or otherwise occupied by patients. Nursing staff are responsible for monitoring the cameras and initiating an immediate response to safety or patient care concerns. This will be a rotating duty with no individual staff member monitoring the cameras for more than two hours consecutively without a break. Patient Safety cameras will not be recorded.

Law Enforcement cameras will be utilized in the following designated Secure and Other areas: The Sally Port entrances/exits (including the immediate hallway area on either side of the Sally Ports), and all Hallways within [unit] 3C. Law Enforcement cameras will not be utilized in any Treatment or Personal areas. Law Enforcement cameras will be monitored in the Police Service Operations Center and will be recorded.⁶⁶

According to the facility’s former Patient Safety Manager, cameras were installed on unit 3C sometime in 2015 to early 2016 to respond to a patient incident.⁶⁷ The former Patient Safety Manager told the OIG that the MHEOCC team at the time had discussions about cameras and was aware of the installation. In March 2016, the facility attempted to activate several new cameras that caused an error resulting in a “crash” of the VA patient care network facility-wide. Reportedly, facility leaders were informed of the occurrence and made decisions that (1) no additional cameras would be added to the existing system, and (2) the facility would immediately

⁶³ Katie Busch, Jan Fawcett, and Douglas Jacobs. Clinical Correlates of Inpatient Suicide. *Journal of Clinical Psychiatry* 64, no. 1 (January 2003): 14–19.

⁶⁴ Asphyxia is a lack of oxygen in the body that results in unconsciousness and often death.

⁶⁵ Facility Memorandum 548-116-67.

⁶⁶ Facility Memorandum 548-116-67.

⁶⁷ The former Patient Safety Manager did not recall the details of the incident.

seek funding to move the security cameras from the VA patient care network to the facility's isolated network. As of the OIG's site visit in late March 2019

- Security cameras had not been moved to their own network,
- Mental health leaders had not requested network space to add unit 3C patient safety cameras, nor did the unit have the capability to monitor the cameras from the nursing station,
- Existing network space, that could reportedly accommodate 130 cameras, had not been prioritized to support surveillance of high-risk areas, and
- The cameras on unit 3C were not functional.

Had the cameras been functional and monitored as required by policy, an employee may have seen the patient preparing for the event (closing the ligature knot in the door frame) in time to intervene. The OIG concedes that an opportunity at real-time intervention was not guaranteed. However, even an after-the-fact recording from the law enforcement cameras could have provided important evidence, such as linen carts left in the hallway or deficits in the 15-minute safety rounds, that could have been used to improve safety processes on unit 3C.

Following the suicide, facility leaders solicited a contract to upgrade the camera system on unit 3C, with an estimated award date of April 29, 2019. The facility provided the OIG a list of patient safety and law enforcement security cameras that were functional and nonfunctional as of April 24, as well as a diagram of current and proposed patient safety and law enforcement security cameras within, and in the immediate vicinity of, unit 3C. The estimated completion date for the camera upgrade and installation was July 31, 2019.

Issue 4. Unit 3C Staffing

While unit 3C staffing was sufficient on the day of the patient's suicide, one of the nursing assistants assigned to conduct 15-minute safety rounds also performed other duties during that time contrary to what was described as the protocol by the unit 3C nurse manager.

VHA Handbook 1160.06, *Inpatient Mental Health Services*, does not define specific inpatient staffing guidelines; however, staffing must be adequate in type and number to provide a safe and therapeutic environment.⁶⁸ At the time of the incident, there were 20 patients with six registered nurses and six nursing assistants on duty. Two of the 20 patients were on 1:1 observation status that required one staff member observing that patient at all times, with no other responsibilities during that assignment.⁶⁹ The unit 3C nurse manager told the OIG team that two of the remaining four nursing assistants were assigned to complete the 15-minute observation checks

⁶⁸ VHA Handbook 1160.06, Section 15 a.

⁶⁹ VHA Directive 1167.

on the other 18 patients. The facility's observation policy did not include if the individual performing the 15-minute rounds could perform other duties during this time.⁷⁰

The unit 3C nurse manager told the OIG that the individuals assigned to do the 15-minute rounding do not perform other duties while performing this task. The OIG interviewed the two nursing assistants who were assigned to the 15-minute checks at the time of the patient's suicide. The first nursing assistant told the OIG that no other tasks should be assigned to staff performing 15-minute rounds. The second nursing assistant, who performed the 15-minute safety rounds on the patient the afternoon of the patient's death, told the OIG that because the unit was small, doing 15-minute checks was easy to accomplish, allowing the rounder to perform other duties. The OIG team learned that the second nursing assistant drew blood on two patients and took vital signs while doing the 15-minute safety rounds. The OIG team could not say with certainty whether the patient's outcome would have been different had the nursing assistant only performed the 15-minute safety rounds. However, the extra duties took additional time and had the potential to delay the timeliness of the 15-minute checks and/or distract the nursing assistant conducting the rounds. Because the hallway security cameras were nonfunctional, no surveillance footage was available for review.

In a 2011 report of an inpatient suicide attempt at the facility, the OIG noted that health technicians, who were assigned to perform the 15-minute safety rounds, were also sometimes assigned concurrent duties.⁷¹ The OIG team found that at the time of the March 2019 site visit, the facility lacked a policy or clear expectations about the duties associated with the 15-minute safety rounds on unit 3C, and staff did not share a consistent understanding of the duties and expectations.⁷²

Issue 5. Leadership Responsiveness

As noted in Issue 2 of this report, various facility leaders and managers knew, or should have known, about on-going lapses related to the unit 3C physical environment, MHEOCC inspection rounds, and staff training. Despite this, responsible leaders and managers did not consistently take steps to educate themselves about and "own" the issue(s), and aggressively problem-solve on behalf of patient safety. As a result, long-standing deficits continued, and some leaders and staff members appeared to accept the often-inaccurate explanations for non-compliance and unsafe conditions. The OIG team noted the following concerns:

- The Chief of Police told the OIG on March 21, 2019, that cameras on 3C were "not required;" that "people rely too much on cameras;" and that "no camera in the world

⁷⁰ Facility Memorandum 548-118-163.

⁷¹ VAOIG Report 11-01052-233, *Attempted Suicide During Treatment, West Palm Beach VA Medical Center, West Palm Beach, Florida*, July 25, 2011.

⁷² The facility provided documentation in May 2019 that unit 3C staff were being trained on the 15-minute rounding requirements; however, the OIG team noted that the training documents did not specify that staff assigned to 15-minute safety rounds could **not** perform other duties such as drawing blood or taking vital signs.

would have given a view” of the patient’s room. The Associate Director, Associate Director for Patient Care Services, and Assistant Director also told the OIG that they were unaware of a requirement for cameras on unit 3C. However, as noted in Issue 3, facility policy required camera surveillance since 2016, and although the inside of the patient’s room would not have been viewable for privacy reasons, on-going monitoring could still elicit important evidence.

- Multiple leaders told the OIG that the MHEOCC rounds did not identify the corridor doors as a safety risk and that over-the-door alarm devices were “not required.” However, solid doors on a mental health unit serving high-risk patients are inherently unsafe, and the MHEOCC did suggest consideration of over-the door alarms. At a minimum, the existence of these doors should have prompted further evaluation of the physical environment, need for door alarms, or enhanced safety rounding.

The OIG also noted that several employees, who should have been knowledgeable about safety requirements on unit 3C, were not. The previous Patient Safety Manager told the OIG of being unfamiliar with over-the-door alarms and unaware of NCPS’s 2013 suggestion for facilities to consider using over-the-door alarms. Also, the Associate Director for Patient Care Services told the OIG that unit 3C was in the process of implementing “enhanced measures,” and the facility was going “above and beyond” to understand the underlying issues to prevent further incidents. The Associate Director for Patient Care Services then cited a review of the linen exchange and counting of eating utensils as examples of the facility’s efforts; however, linen exchange and utensil counts are long-standing and basic safety requirements.

Another illustration of a leader’s lack of knowledge or attempt to minimize the significance of safety concerns on unit 3C was when, prior to the patient’s suicide, the current Patient Safety Manager reported to facility leaders in a group forum that some unit 3C physical environment conditions represented an “immediate threat to life.” The Associate Director reportedly cautioned the Patient Safety Manager that using the term “immediate threat to life” was “strong” and to “be careful what you say.”

After the patient’s death, the facility initiated an investigation as required.⁷³ The facility closed unit 3C to new admissions to evaluate processes and safety risks. TJC was notified of the sentinel event, and staff were offered counseling and support. As a result of the investigation, the facility initiated a risk mitigation action plan to include more frequent, variable, and random safety rounding; reduced the clinical threshold for instituting 1:1 or close observation; initiated contracts to install over-the-door alarm systems; and contracted for enhancements to the camera

⁷³ VHA Handbook 1050.01, page 8.

surveillance program. Facility leaders also completed an institutional disclosure with members of the patient's family.⁷⁴

While the OIG team determined that the facility responded promptly to this adverse patient event, the team identified that facility leaders and managers only started to respond aggressively to long-standing deficient conditions after a sentinel event occurred.

⁷⁴ VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018. "An institutional disclosure of adverse events is a formal process by which VA medical facility leader(s), together with clinicians and others as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse."

Conclusion

The patient received reasonable care while admitted to the acute inpatient psychiatry unit. The patient was appropriately screened for suicide risk, provided medication management, placed on close observation status, and had on-going assessments, interventions, and a discharge plan by physicians, nurses, and social workers. However, the OIG team noted that there was no single unifying treatment plan that conveyed the patient-specific plan of care with measurable goals and interventions as required by VHA and TJC.

The facility conducted MHEOCC rounds every six months on unit 3C as required by VHA. However, the OIG team identified the facility did not meet expectations with ISIT requirements and MHEOCC training. Also, the facility had not been proactive in the critical evaluation of the unit 3C environment.

For almost seven years, VHA leaders, the NCPS, and TJC have written memoranda, conducted training, published design guides, and/or published peer-reviewed journal articles that identified doors as potential anchor point hazards requiring some type of action to mitigate the risk. However, facility managers failed to consider or identify the corridor doors to be potential anchor point hazards. The OIG team also found inadequate oversight by the VHA-level MHEOCC Working Group and VISN 8 leadership.

Risk mitigation strategies used on unit 3C could not reliably assure patient safety. While the facility staff conducted 15-minute rounds for most patients, it would be possible to have a span exceeding 25 minutes when a patient was not visually observed by a staff member. The patient safety and law enforcement cameras, required by facility policy, had not been operational for at least three years. Although a patient eloped from unit 3C nearly three months before the patient's suicide, an internal review of the elopement did not identify or address the non-operational law enforcement security cameras. Had the cameras been fixed and monitored as required by policy, it is possible that an employee may have seen the patient preparing for the event, and possibly been able to intervene. An after-the-fact recording from the law enforcement cameras could have potentially elicited important evidence that could be used to improve safety processes on unit 3C.

While 3C staffing appeared sufficient on the day of the patient's suicide, one of the nursing assistants assigned to conduct safety rounds also performed other duties during that time contrary to unit 3C protocol. The OIG team determined that the facility lacked a policy or clear expectations regarding 15-minute safety rounds, and staff did not have a consistent understanding of their duties regarding safety rounds.

Overall, the OIG found that facility leaders lacked awareness of patient safety requirements and related issues on unit 3C and appeared to accept inaccurate explanations for non-compliance and unsafe conditions. Leaders' failures to educate themselves about camera-related requirements on unit 3C, even after the December elopement and the early 2019 suicide, represented, in the OIG's view, a deflection of responsibility and failure to perform their duties. At the senior

leadership level, the refrain of the doors not being a safety risk and door alarms not being required reflected, in the OIG's view, a myopic view of the facility's responsibility to ensure patient safety.

While the OIG team determined that the facility responded promptly to this adverse patient event and is in the process of implementing improvement actions, the team noted facility leaders and managers only started to respond aggressively to long-standing deficient conditions after a sentinel event occurred.

Recommendations 1–11

1. The West Palm Beach VA Medical Center Director ensures that mental health multidisciplinary treatment plans are completed in accordance with Veterans Health Administration and The Joint Commission guidelines.
2. The West Palm Beach VA Medical Center Director ensures immediate compliance with Veterans Health Administration guidelines regarding the Interdisciplinary Safety Inspection Team and its associated functions.
3. The West Palm Beach VA Medical Center Director ensures immediate compliance with Veterans Health Administration guidelines regarding Mental Health Environment of Care Checklist training prior to entry on unit 3C and annually thereafter.
4. The West Palm Beach VA Medical Center Director ensures that the Employee Education Service staff assigns Mental Health Environment of Care Checklist on-line training modules to employees according to their duties and assignments.
5. The West Palm Beach VA Medical Center Director ensures that deficiencies identified during the Mental Health Environment of Care Checklist inspections are abated according to VHA guidelines, and that appropriate risk mitigation strategies are implemented as needed.
6. The Veterans Integrated Service Network Director ensures that the appropriate Veterans Integrated Service Network level staff complies with guidelines to review semi-annual reports and follow-up to ensure abatement of deficiencies prior to item closure on the Mental Health Environment of Care Checklist.
7. The Under Secretary for Health takes action to ensure that the Mental Health Environment of Care Checklist Work Group reviews and ranks hazards as submitted through the Patient Safety Assessment Tool, and ensures abatement (or waiver of abatement), as indicated.⁷⁵
8. The West Palm Beach VA Medical Center Director ensures that patient safety and law enforcement cameras are installed, tested, and monitored according to West Palm Beach VA Medical Center and Veterans Health Administration guidelines.
9. The West Palm Beach VA Medical Center Director ensures that a policy on 15-minute safety rounding expectations be developed, and that all permanent and temporarily-assigned staff performing 15-minute safety rounding on unit 3C receive appropriate training regarding their duties.
10. The West Palm Beach VA Medical Center Director develops a mechanism to confirm staff compliance with 15-minute rounding requirements.

⁷⁵ 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.

11. The West Palm Beach VA Medical Center Director ensures that managers and leaders with mental health, environment of care, and patient safety-related responsibilities are knowledgeable about areas and policies governing the areas under their purview.

Appendix A: Under Secretary for Health Comments

Department of Veterans Affairs Memorandum

Date: July 26, 2019

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

Subj: OIG Draft Report, Healthcare Inspection—Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center, Florida (VIEWS #01357219)

To: Assistant Inspector General for Healthcare (54)

1. Thank you for the opportunity to review the draft report on the inspection of the Mental Health Unit at West Palm Beach VA Medical Center.
2. I concur with recommendation 7 and provide the attached action plan. Action plans for recommendations 1-6 and 8-11 are found under comments by the Medical Center and VISN Director.
3. If you have any questions, please email Karen Rasmussen, M.D., Director for GAO-OIG Accountability Liaison at VHA10EGGOALAction@va.gov.

(Original signed by:)

Richard A. Stone, M.D.
Executive in Charge

Comments to OIG's Report

Recommendation 7

The Under Secretary for Health takes action to ensure that the Mental Health Environment of Care Checklist Work Group reviews and ranks hazards as submitted through the Patient Safety Assessment Tool, and ensures abatement (or waiver of abatement), as indicated.

Concur.

Executive in Charge Comments

The Office of Mental Health and Suicide Prevention will ensure that each Veterans Integrated Service Network (VISN) Mental Health Service Line Manager reviews the results of the Mental Health Environment of Care Checklist (MHOECC), dated January 15, 2019, in the Patient Safety Assessment Tool. The VISN Mental Health Service Line Manager will ensure that any identified hazards have been abated and have a plan in place to mitigate the hazard for all Mental Health Units in their respective VISNs that use the MHEOCC.

Any environmental suicide hazard that is identified by the facility must be abated or appealed to the MHEOCC review board for review within six months of identifying the hazard.

Status:
In Process

Target Completion Date:
September 2019

Appendix B: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 15, 2019

From: Director, VA Sunshine Healthcare Network (10N8)

Subj: Healthcare Inspection—Patient Suicide on a Locked Mental Health Unit at the West Palm Beach VA Medical Center, Florida

To: Director, Office of Healthcare Inspections, Rapid Response (54RR00)
Director, GAO/OIG Accountability Liaison Office (VHA 10EG GOAL Action)

1. Thank you for the opportunity to review the draft report of your review of care which focuses on events that occurred at the West Palm Beach VA Medical Center. I appreciate the Office of the Inspector General's oversight and the extensive work done as part of this review. While we have concerns regarding some of the OIG findings and description of those findings, we acknowledge there are improvements to be made and we are committed to ensuring a safe environment is provided for each Veteran.
2. Since the OIG's visit, a thorough review of how care is provided in the inpatient mental health setting at the West Palm Beach VAMC has been completed. A corrective action plan to enhance healthcare delivery has been implemented as detailed in the attached report.
3. I have reviewed the Healthcare System Director's action plan and projected completion dates and I concur. VISN 8 will assist the Healthcare System's leadership in reaching full compliance in a timely manner.

(Original signed by:)

Miguel H. LaPuz, MD, MBA
Director, VA Sunshine Healthcare Network

Comments to OIG's Report

Recommendation 6

The Veterans Integrated Service Network Director ensures that the appropriate Veterans Integrated Service Network level staff complies with guidelines to review semi-annual reports and follow-up to ensure abatement of deficiencies prior to item closure on the Mental Health Environment of Care Checklist.

Concur.

Target date for completion: August 2019

Director Comments

Veterans Integrated Service Network (VISN) 8 will enhance the procedures in place that provides oversight and review of semi-annual Mental Health Environment of Care Checklist (MHEOCC) submissions by having the following staff collaborate on the process: VISN 8 Mental Health Lead, VISN 8 Safety Officer, VISN 8 Patient Safety Officer, and VISN 8 Quality Management Officer. This group will evaluate MHEOCC documents against the previous submission to ensure consistent review of the unit has occurred, to determine if appropriate risk mitigation strategies are in place, and to track closure of any previously open items.

Appendix C: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 24, 2019

From: Director, West Palm Beach VA Medical Center (548/00)

Subj: Healthcare Inspection—Patient Suicide on a Locked Mental Health Unit West Palm Beach VA Medical Center, FL

To: Director, VA Sunshine Healthcare Network (10N8)

1. Thank you for the opportunity to review the draft report of the West Palm Beach Veterans Affairs Medical Center inspection. I have reviewed the document and concur with the recommendations.
2. A plan of action for each recommendation is attached. The plans of action have been carefully analyzed and will be implemented and monitored through satisfactory completion.

(Original signed by:)

Donna Katen-Bahensky, MSPH
Director, West Palm Beach VA Medical Center

Comments to OIG's Report

Recommendation 1

The West Palm Beach VA Medical Center Director ensures that mental health multidisciplinary treatment plans are completed in accordance with Veterans Health Administration and The Joint Commission guidelines.

Concur.

Target date for completion: September 2019

Director Comments

As of June 21, 2019, the West Palm Beach VA solicited best practice feedback from other facilities to implement standardized multidisciplinary treatment plans. On July 1, 2019, a multidisciplinary treatment plan was implemented. As of July 1, 2019, audits of no less than 20 records per month were completed to ensure no less than 90 percent compliance on the use of multidisciplinary treatment plans.

Mental Health Suite software is used to complete treatment plans. The treatment plan is initiated within 24 hours and completed within 72 hours of admission. As of July 1, 2019, audits are taking place to ensure compliance with utilization of the software. Threshold for completion will be 90 percent compliance for three consecutive months.

Recommendation 2

The West Palm Beach VA Medical Center Director ensures immediate compliance with Veterans Health Administration guidelines regarding the Interdisciplinary Safety Inspection Team and its associated functions.

Concur.

Target date for completion: Complete

Director Comments

The Interdisciplinary Safety Inspection Team (ISIT) Charter Memo was created and signed by the Medical Center Director to ensure compliance with VHA guidelines regarding ISIT and its associated functions. The memo was sent to the ISIT members and they were briefed at the first ISIT monthly meeting. The first ISIT monthly meeting was held on April 30, 2019.

OIG Comment

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

Recommendation 3

The West Palm Beach VA Medical Center Director ensures immediate compliance with Veterans Health Administration guidelines regarding Mental Health Environment of Care Checklist training prior to entry on unit 3C and annually thereafter.

Concur.

Target date for completion: September 2019

Director Comments

On June 6, 2019 the Mental Health Environment of Care Checklist (MHEOCC) training program update was completed in Talent Management System (TMS) by the TMS Domain Manager. The MHEOCC Training for Clinical Staff (TMS Item # 129-945) and MHEOCC Training for Non-Clinical Staff (TMS Item #1290950) was assigned to all current 3C staff and new employees. On July 5, 2019, nursing staff assigned to work on unit 3C were assigned the required TMS Mental Health module with a goal completion date of September 30, 2019. This will be monitored to ensure 100 percent of staff working on unit 3C complete this required education.

Recommendation 4

The West Palm Beach VA Medical Center Director ensures that the Employee Education Service staff assigns Mental Health Environment of Care Checklist on-line training modules to employees according to their duties and assignments.

Concur.

Target date for completion: Complete

Director Comments

The facility set a target rate of a 90 percent compliance for this Mental Health Environment of Care Checklist (MHEOCC) training. Currently, 99 percent of assigned staff has completed the MHEOCC training: 920 of 927 clinical staff completed the MHEOCC training and 367 of 367 of non-clinical staff completed the MHEOCC training. The Chief Registered Nurse for Mental Health requested all current 3C staff and new employees assigned to 3C to be assigned MHEOCC training in their learning plan for clinical staff to include a yearly refresher training. As of June 28, 2019, 100 percent of staff assigned to 3C have completed their TMS MHEOCC

training module. West Palm Beach considers this recommendation complete and requests closure.

OIG Comment

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

Recommendation 5

The West Palm Beach VA Medical Center Director ensures that deficiencies identified during the Mental Health Environment of Care Checklist inspections are abated according to Veterans Health Administration guidelines, and that appropriate risk mitigation strategies are implemented as needed.

Concur.

Target date for completion: August 2019

Director Comments

On July 19, 2019, the Mental Health Environment of Care Checklist and Medical Center Policy were reviewed by the Interdisciplinary Safety Inspection Team (ISIT) team. The finalized medical center policy will be sent out for collaboration and Medical Center Director signature. Completion of the recommendation will be accomplished upon submission of the finalized policy to the Office of Inspector General.

Recommendation 8

The West Palm Beach VA Medical Center Director ensures that patient safety and law enforcement cameras are installed, tested, and monitored according to West Palm Beach VA Medical Center and Veterans Health Administration guidelines.

Concur.

Target date for completion: August 2019

Director Comments

As of July 11, 2019, 10 of 15 security cameras are operational on the acute behavioral health unit (3C). The remaining cameras are anticipated to be activated on August 31, 2019, pending any issues related to the separation of network to have a single network for the security cameras.

Patient safety cameras on 3C have been installed and tested. Activation of the cameras and monitoring is anticipated to begin by August 31, 2019.

Recommendation 9

The West Palm Beach VA Medical Center Director ensures that a policy on 15-minute safety rounding expectations be developed, and that all permanent and temporarily-assigned staff performing 15-minute safety rounding on unit 3C receive appropriate training regarding their duties.

Concur.

Target date for completion: Complete

Director Comments

A policy on 15-minute safety rounding expectations was completed on May 30, 2019, and all nursing staff on Unit 3C have received training regarding their duties. Compliance with training is 100 percent with 37/37 staff having completed training of July 2019. West Palm Beach considers this recommendation complete and requests closure.

OIG Comment

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

Recommendation 10

The West Palm Beach VA Medical Center Director develops a mechanism to confirm staff compliance with 15-minute rounding requirements.

Concur.

Target date for completion: September 2019

Director Comments

During unit rounding, the Chief Nurse and 3C unit managers performs focused leadership rounding in addition to the monthly audits. Any concerns identified are immediately addressed.

As of April 2019, an audit tool was developed and currently implemented with a compliance rate of 100 percent for the months of April, May, and June 2019.

A review of the audit tool indicated additional opportunities for details of specific observations made and appropriate actions taken therefore the tool was revised and implemented the first week of July 2019. Threshold for completion will be 90 percent compliance for three consecutive months.

Recommendation 11

The West Palm Beach VA Medical Center Director ensures that managers and leaders with mental health, environment of care, and patient safety-related responsibilities are knowledgeable about areas and policies governing the areas under their purview.

Concur.

Target date for completion: August 2019

Director Comments

All members of the Pentad will be required to complete Mental Health Environment of Care Checklist (MHEOOC) for Mental Health Units Treating Suicidal Patients training. This training was completed for all Pentad members as of June 28, 2019. Additionally, all Pentad members are required to review and attest to understanding of related VHA Directives, Handbooks and local policies related to mental health, environment of care, and patient safety-related responsibilities.

The Associate Director for Patient Care Services (ADPCS), the Deputy Nurse Executive, and the Chief Nurse of Mental Health have reviewed and revised the Chief Nurse of Mental Health orientation plan provided by the Office of Nursing Service (ONS), as well as VHA Directives, Handbooks, and local policies. Additionally, managers and leaders with behavioral health and mental health environmental safety duties and/or oversight have also been educated regarding local policies and procedures related to mental health, environment of care, and patient safety-related responsibilities. A total of 43 managers and leaders representing the key services with roles and responsibilities have been identified to complete training by August 30, 2019.

The Patient Safety Manager has reviewed all VHA Directives related to the MHEOOC and ISIT Processes and has educated the team members on their roles and responsibilities. The Patient Safety Manager has established a new in-depth briefing with the Pentad and support staff that details the findings on the MHEOCC checklist so they are aware of all deficiencies and what actions that need to be taken.

OIG Contact and Staff Acknowledgments

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