Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Alleged Mental Health Issues
Fargo VA Medical Center
Fargo, North Dakota

Report No. 09-01636-113

March 23, 2010

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The purpose of this review was to determine the validity of allegations regarding failure to properly assess and assist patients with mental health (MH) conditions and substance use disorders and that these failures contributed to the deaths of at least three patients at the Fargo VA Medical Center (the medical center), Fargo, North Dakota. The complainant further alleged that there was a lack of adequate training, qualifications, and supervision of addiction therapists; and a general attitude of uncaring and lack of professionalism among staff.

We did not substantiate the allegation that the patients' deaths were a result of failure to provide adequate care. Two of the deaths were determined to be accidental and the third was a suicide. The medical center had conducted thorough reviews of the care of the three patients. The patients had multiple encounters with the medical center and often refused services offered. All three had recent assessments prior to their deaths that indicated they were not at risk for suicide. There was no evidence to support that the deaths of the three patients were due to lack of proper assessment, evaluation, or assistance.

We did not substantiate the allegation that addiction therapists lacked training, were not qualified or competent to provide care to patients with MH and substance abuse disorders, or that they were inadequately supervised. We determined that addiction therapists met Veterans Health Administration (VHA) standards for education and training and were appropriately supervised. Although all therapists had training, education or experience in the area of substance abuse, rapid expansion of MH programs and hiring of staff from many areas resulted in variations in practice. Program managers had implemented the use of standardized criteria to improve consistency in the provision of care.

We did not substantiate an atmosphere of uncaring and unprofessionalism in the substance abuse program. During our site visit, we did not observe or identify issues related to an unprofessional work environment. There were normal work related conflicts in an area that had experienced rapid growth with staff from multiple professional backgrounds but our interviews and observations did not reveal significant problems.

The Acting Veterans Integrated Service Network and Acting Medical Center Directors agreed with our findings. We did not make any recommendations.

DEPARTMENT OF VETERANS AFFAIRS
Office of Inspector General
Washington, DC 20420

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

SUBJECT: Healthcare Inspection – Alleged Mental Health Issues, Fargo VA Medical Center, Fargo, North Dakota

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections conducted an inspection to determine the validity of allegations regarding failure to properly assess and assist patients with mental health (MH) conditions and substance use disorders and that these failures contributed to the deaths of at least three patients at the Fargo VA Medical Center, Fargo, North Dakota.

Background

The medical center provides a broad range of inpatient and outpatient health care services including medical, surgical, MH, and long term care services. The medical center has 42 inpatient beds and 38 community living center beds. Treatment programs include the Healthcare for Homeless Veterans Program and the Substance Abuse Treatment Program. The medical center is affiliated with the University of North Dakota School of Medicine and is part of Veterans Integrated Service Network (VISN) 23.

The OIG received allegations from a complainant alleging quality of care issues related to patients with MH and substance use disorders. The specific allegations included failures to assess and assist patients with MH and substance use disorders; lack of adequate training, qualifications, and supervision of addiction therapists; and a general attitude of uncaring and lack of professionalism among staff. The complainant identified three patients who died and alleged that care failures contributed to their deaths. In addition, the complainant alleged that staff at the medical center could give us names of six additional patients who died of suicide and drug addiction while receiving care at the medical center.

We interviewed the Chief of Staff (COS) regarding the MH program during the time period of the allegations. He reported that on September 25, 2007, the locked inpatient

MH unit at the medical center was closed for a major renovation in order to meet life safety codes. This unit was reopened on October 30, 2008. From September 2007 through July 2008, the medical center had three temporary beds located on an open ward available for MH patients who were stable. Most patients who needed psychiatric hospitalization during the renovation were referred to community hospitals through the Non-VA Care (Fee Program).[1] Fee basis care increased with the closing of the inpatient MH unit. Case managers reviewed this care regularly and found that it met quality standards.

There was a rapid, substantial growth in MH programs during this same time period. Increased workloads contributed to interpersonal conflict among staff. Funds were made available for workload increases and the medical center hired approximately 20 new staff in MH. The COS stated he specifically recruited a new Chief of Mental Health to assist with program development.

Scope and Methodology

We conducted a site visit at the medical center on June 22–25, 2009, and interviewed physicians, nurses, addiction therapists, a social worker, suicide prevention coordinator, patient advocate, quality management staff, and medical staff leadership. We interviewed the complainant to obtain clarification of the allegations. We reviewed medical center policies, procedures, directives, quality data, and patient and employee records. We also reviewed patient information regarding care and treatment from fee basis providers in the community and the Medical Examiner (ME).

Although the complaint indicated that MH staff at the medical center would provide the names of additional patients who died from suicide or drug addiction, staff were unable to provide this information.

We conducted the inspection in accordance with *Quality Standards for Inspections* published by the President's Council on Integrity and Efficiency.

Inspection Results

Clinical Case Reviews

Patient A

Patient A was a Vietnam veteran in his fifties, who was 100 percent service connected for hepatitis C, major depressive disorder, and back and shoulder problems. His medical history included many years of substance abuse, mood disorder, hypertension, anemia,

[1] When the VA cannot provide all the necessary medical care and services, the VA may authorize medical care in the community for those veterans who meet the eligibility requirements.

depression, chronic pain, esophageal reflux disease, and anxiety. He had multiple encounters at the medical center for these conditions. The patient had intermittent housing problems for the previous 12 years.

The patient was last seen at the medical center in late November 2007. He presented to the primary care (PC) walk-in clinic with complaints of a recent fall while intoxicated and severe depression. He was seen by the PC nurse who assessed pain in his right foot, both knees, and his elbow and shoulder resulting from the fall the night before. In addition, the nurse noted an elevated blood pressure with the patient admitting failure to take his blood pressure medications as ordered. He was sent to the Mental Health Clinic (MHC) to be seen for his depression and instructed to return to PC afterwards for evaluation of his high blood pressure.

He was evaluated by the MHC triage nurse who noted he was alert and oriented with logical goal directed thoughts. The patient reported he had been struggling emotionally and feeling more depressed over the last month. He stated his daughter had been using drugs and had locked him out of the apartment after an argument over a stolen wallet. He reported he had since been staying with friends. He admitted he was drinking again, but he was not intoxicated, and reported his last drink as the night before. He stated he just did not feel safe and yet did not know what he wanted. He reported no thoughts of suicide, suicide plans, or intent. His complaints were vague and when asked directly if his main concern was housing and a place to stay, he said yes.

The MHC triage nurse contacted the inpatient psychiatrist by telephone and communicated the patient assessment. The psychiatrist was familiar with the patient and told the MHC triage nurse that because the assessment sounded like previous presentations the patient did not require hospitalization. The plan was to offer substance abuse therapy, homeless services, and refill medications. The patient was not seen at this time by the psychiatrist.

The patient refused the substance abuse therapy and homeless services and said he might go to the Minneapolis VA the next day for their substance abuse program, but refused help to arrange this visit. He refused to address the housing situation but accepted the refill of his anti-depressant medication and was given bus tokens for transportation. The patient had been offered homeless services in the past, but did not follow through with plans made during these visits. He did not return to PC as instructed, for evaluation and treatment of his high blood pressure.

The patient was found unresponsive at a local bus stop kiosk in early December 2007. He was taken to the county ME office where an autopsy showed he died of hypothermia and an elevated blood alcohol level. There was no evidence of trauma and the ME report was negative for skull abnormalities or blood clots that might occur after a fall. His death was considered accidental, not a suicide.

Patient B

Patient B was a female, Persian Gulf War veteran in her early forties. She was 100 percent service connected for bipolar disorder. The medical center had treated her often for this, substance abuse (benzodiazepines and dextromethoraphan), and kidney stones.

She was last seen at the medical center in early July 2008, for a routine MHC appointment where she reported doing well and maintaining her sobriety. Prior to this, she completed an inpatient stay at a local hospital for suicidal ideation and substance abuse and a subsequent residential treatment program. She was working towards completion of a master's degree and denied homicidal or suicidal ideations.

She called the medical center 23 days later requesting documentation of her 100 percent service connected disability in order to try to have her student loans forgiven, and called again 2 days later asking for a renewal of one of her medications. The renewal was completed that same day. This was her last contact with the medical center.

Four days later, her family went to her home to check on her as they had not heard from her for several days. She was found dead in her home and was transported to the county ME office for autopsy. The ME report identified the cause of death as mixed drug toxicity with the presence of benzodiazepines and dextromethoraphan. The death certificate noted the death as accidental.

Patient C

Patient C was a male Persian Gulf War veteran in his thirties with severe alcohol dependence, hypertension, depressive disorder, anxiety, personality disorder, gastro-esophageal reflux, post-traumatic stress disorder, and childhood sexual abuse. He had a long history with the medical center for these problems and was 10 percent service connected for hearing loss. His history included multiple fee basis admissions for acute MH problems and care at several residential treatment programs.

In late July 2008, the patient was admitted to Project Hart (PH) which provides transitional residential treatment to homeless veterans. On hospital day (HD) 11, he requested a weekend pass to visit his family. PH staff contacted the family to discuss the pass prior to approval. The patient had been depressed about his pending divorce, but denied suicidal ideation or plans. The family stated the patient would be around family all weekend, and there would be no alcohol or drugs available. The pass was approved.

Two days later, the patient's family notified PH that the patient had taken his life at their home. The family reported they left the patient at home alone while they attended a wedding. The patient reportedly broke into a gun case and shot himself. The ME report shows serum toxicity as positive for dexamethoraphan and urine drug screen positive for

hydrocodone, and indicated the patient died from a gunshot wound to the head. His blood alcohol was negative. The death certificate indicated the death as suicide.

Issue 1: Failures in the Provision of Care Contributed to Patients Deaths

We did not substantiate the allegation that the patients' deaths were a result of failure to provide adequate care. All of the cases were reviewed through the medical center's quality management review processes and management took appropriate actions as needed.

We found that Patient A was offered and refused appropriate care and services. During the patient's visit to the medical center in late November 2007, he was assessed by nurses in PC and MHC and health problems were identified. Although the patient was not assessed by a PC or MH licensed independent provider, it does not appear that this contributed to his death.

The medical center did implement a change in care processes after review of this case. They determined that all patients who walk in to the medical center and have identified MH needs must be seen by a licensed independent practitioner prior to leaving the medical center.

We concluded that Patient B was provided appropriate care. The patient reported sobriety to the medical center at her last clinic appointment. Her medication refill request was completed, and she continued to deny suicidal ideations.

Patient C was provided care for MH and substance abuse on multiple occasions and was not determined to be at risk for suicide at the time of his pass to spend time with his family. Family members had stated they would be with him during the time of the authorized pass.

Issue 2: Addiction Therapists Not Adequately Trained, Qualified, or Supervised

We did not substantiate that addiction therapists lacked training, were not qualified or competent to provide care to patients with MH and substance abuse disorders, or that they were inadequately supervised.

Licensure is not required for addiction therapists within the VA. We reviewed the personnel files for three addiction therapists and found specific work experience or training in MH and substance abuse. We interviewed the supervisor of the substance abuse program who reported that when he was hired in October 2008, the staff used a variety of criteria for assessment and treatment of patients. He has since implemented organizational changes that include the use of American Society of Addiction Medicine criteria for all phases of the program. This criteria guides decisions for admission to

various programs and has been disseminated to other departments for use in making referrals. At the time of our visit, he had provided two workshops for the staff.

We interviewed the Chief of Mental Health who reported he was hired in November 2007. He requested and received an external substance abuse treatment program consultation to assist in his program evaluation. In addition, he conducted competency evaluations on all staff after 6 months of observation, interviews, and patient medical record reviews. He determined that staff were adequately qualified but because of the rapid expansion of programs and hiring of staff from many areas, variation in practice was identified as an opportunity for improvement. He initiated processes to encourage standardization.

Issue 3: Failure to Provide a Professional Work Environment

We did not substantiate an atmosphere of uncaring and unprofessionalism in the substance abuse program.

We interviewed staff from within the program and from other services. Although two staff reported hearing a negative remark at one time, neither believed the overall atmosphere was unprofessional or uncaring. There were normal work related conflicts in an area that had experienced rapid growth with staff from multiple personal and professional backgrounds but our interviews did not reveal significant problems.

Conclusions

There was no evidence to support that the deaths of the three patients were due to lack of proper assessment, evaluation, or assistance. The medical center conducted thorough reviews of the care of the patients. We determined that addiction therapists met VHA standards for education and training. The Chief of Mental Health had identified variations in practice within the service and implemented changes to improve consistency in care. During our site visit, we did not observe or identify issues related to an unprofessional work environment. Therefore, we did not make any recommendations.

Comments

The Acting VISN and Medical Center Directors concurred with the inspection results (see Appendixes A and B, pages 8–9 for the full text of their comments).

(original signed by:)
JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

Acting VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: January 26, 2010

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

Subject: **Healthcare Inspection – Alleged Mental Health Issues, Fargo VA Medical Center, Fargo, North Dakota**

To: Director, Kansas City Office of Healthcare Inspection (54KC)

Thank you for the opportunity to review this draft report.

Cynthia Breyfogle

Cynthia Breyfogle, FACHE

Appendix B

Acting Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

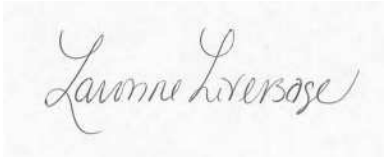
Date: January 19, 2010

From: Acting Director, Fargo VA Medical Center (437/00)

Subject: **Healthcare Inspection – Alleged Mental Health Issues, Fargo VA Medical Center, Fargo, North Dakota**

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

I have reviewed and concur with the findings in this report. I would like to express my appreciation to the team who conducted the review for its professional and comprehensive review and approach.



LAVONNE LIVERSAGE, FACHE

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Dorothy Duncan, BSN, MHA, RN, CPHQ Associate Director, Kansas City Office of Healthcare Inspections (816) 997-6966
Acknowledgments	Verena Briley-Hudson, MN, RN Judy Brown Jennifer Kubiak, BSN, MPH, RN, CPHQ Michael Shepherd, MD Roberta Thompson, MSW

Appendix D

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