Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Suicide After an Emergency Department Visit at the Dayton VA Medical Center Dayton, Ohio

Report No. 10-02278-26

November 9, 2010

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections received a Congressional request to evaluate the care of a patient who committed suicide on the grounds of the Dayton VA Medical Center (the medical center), in Dayton, Ohio, after leaving the emergency department (ED). We found that the ED staff made reasonable efforts to provide treatment to the patient in the hours preceding his suicide. In addition, we found that the patient received appropriate and ongoing primary care and mental health (MH) services prior to the event. We also found that providers made appropriate efforts to manage the patient's pain and treat his MH conditions from August 2008 to April 2010.

However, we found opportunities to improve communication and suicide risk management training. We recommended that the VISN Director ensure that the Medical Center Director requires providers to optimize appropriate "hand-off" and intra-staff communication and requires clinical staff to complete Veterans Health Administration's mandatory suicide risk management training. The VISN and Medical Center Directors concurred with the recommendations and provided acceptable action plans.

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

TO: Director, Veterans Integrated Service Network (10N10)

SUBJECT: Healthcare Inspection – Suicide After an Emergency Department Visit at the Dayton VA Medical Center, Dayton, OH

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections (OHI), conducted an evaluation to review the care of a patient who committed suicide, reportedly after seeking treatment at the Dayton VA Medical Center (the medical center) emergency department (ED).

Background

The Honorable Steven Buyer, Representative from the 4th Congressional District of Indiana and ranking member of the Committee on Veteran's Affairs, requested that the OIG review the care of a patient who committed suicide on the grounds of the medical center after leaving the ED. The medical center provides inpatient and outpatient medical, surgical, mental health, and geriatric specialty services. It operates 500 hospital beds (265 nursing home beds, 120 acute care beds, and 115 domiciliary beds) and provides services at four community based outpatient clinics located in Lima, Middletown, and Springfield, Ohio; and Richmond, Indiana. The medical center is part of Veterans Integrated Service Network (VISN) 10.

Scope and Methodology

We conducted a site visit on June 22–23, 2010. Prior to our visit, we reviewed local and Veterans Health Administration (VHA) policies, directives, and suicide risk assessment references; the patient's medical record, autopsy report, and related toxicology test results; quality management documents; the police report; and the American Psychiatric Association guideline on suicide assessment and prevention. While onsite, we interviewed the patient's sibling, clinical and administrative staff with knowledge of the

patient's ED visit, the Suicide Prevention Coordinator, and designated Freedom Center[1] staff. In addition, we interviewed a friend of the patient who provided additional information. We also reviewed the training records of all ED staff and toured the ED.

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

Case Summary

Summary of Patient's Treatment Prior to Suicide

The patient was an Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veteran in his twenties who served in the Army from 2001-2005. He suffered a back injury in Iraq when an improvised explosive device (IED) exploded near his combat vehicle, causing acute and progressive back pain. He underwent lower back surgery in 2006. He was 80-percent service-connected for diagnoses of major depressive disorder (MDD) and degenerative arthritis of the spine. His other diagnoses included post-traumatic stress disorder (PTSD) and chronic lower back pain,

The patient first presented to the medical center's ED in August 2008 complaining of pain and depression, and the ED provider sent consultation requests to both primary care and mental health (MH). A primary care provider saw the patient in September 2008 and prescribed an antidepressant and a muscle relaxant.

The patient first saw a MH provider, a social worker, in early October 2008. The social worker's psychosocial assessment[2] listed the patient's complaints as emotional numbness, excessive sleeping, and crying spells. The MH social worker's treatment plan noted that the patient did not want psychotherapy, but he was agreeable to seeing a psychiatrist for his depression.

In December, the patient began seeing the Freedom Center PCP (FCPCP) for medical follow-up and pain management. The FCPCP saw the patient from December 2008 until March 2010, and during the course of treatment, prescribed various non-steroidal anti-inflammatory drugs (NSAIDs),[3] gabapentin,[4] topical analgesics, muscle relaxants, and

[1] The medical center's post deployment clinic for OEF/OIF veterans that provides primary care services and case management.
[2] An evaluation of a person's mental health, social status, and functional capacity within the community.
[3] NSAIDs have analgesic and fever-reducing effects (ex: Aspirin, Ibuprofen and naproxen).
[4] Gabapentin is in a class of medications called anticonvulsants. This medication may be prescribed at times for other uses such as different types of pain. http://www.nlm.nih.gov/medlineplus/druginfo/meds/a694007.html

opioids[5] for his pain. He also suggested MH therapy on several occasions, but the patient declined.

Between January 2009 and April 2010, the patient also had four appointments with a MH nurse practitioner for medication management, three appointments with a MH clinic psychiatrist, and multiple ED visits, primarily for back pain and depression. The patient vacillated between a desire to be medication free and a desire for symptom reduction. The medical record reflects a history of sporadic compliance with his prescribed psychotropic medications.

The patient did not show up for a mid-June Interventional Radiology appointment for a lumbar epidural steroid injection (LESI).

The patient was voluntarily admitted to the inpatient mental health unit in early August 2009. He was discharged in stable condition and readmitted about 2 weeks later. Prior to each discharge from the MH unit, an inpatient MH provider evaluated the patient and determined that he was "low"[6] risk for suicide.

In September 2009, the patient accepted temporary admission to the medical center's domiciliary while awaiting acceptance into a residential inpatient PTSD program at the Martinsburg VA medical center (VAMC) in West Virginia. He only stayed a few hours before leaving the domiciliary; he denied suicidal ideation at the time of his departure. The patient returned the following day and received a LESI.

From mid-September to late December 2009, the patient received residential PTSD treatment at the Martinsburg VAMC. He successfully completed the program.

In January 2010, the patient was involuntarily admitted to the inpatient mental health unit for suicidality as he had refused voluntary admission. He was discharged in stable condition 3 days later.

In March 2010, the patient presented to the ED complaining of anxiety aggravated by chronic pain. The patient agreed to voluntary admission to the inpatient MH unit; however, the patient left the ED before the admission could be completed. The ED physician documented that despite the patient's clear distress and need for treatment, he did not meet criteria for involuntary admission.

In early April 2010, the patient went to Anchorage, Alaska, to retrieve his vehicle. While there, he presented to the Anchorage VA primary care clinic requesting pain medication.

[5] Opioids are commonly prescribed because of their effective analgesic, or pain-relieving, properties. Medications that fall within this class–referred to as prescription narcotics–include morphine, codeine, and oxycodone.
[6] The degree of suicide risk is categorized as low, moderate, high, and imminent. Low risk indicates no notable risk factors and substantial protective factors.

He rated his pain as 7 out of 10 and the provider prescribed a 30-day supply of a narcotic pain medication. The patient returned to Dayton shortly thereafter.

Summary of Patient's ED Visit on Date of Suicide

In April 2010, the patient presented to the medical center's ED shortly after midnight. wearing his combat attire. The Administrative Officer of the Day (AOD) informed a registered nurse (Nurse A) that the veteran needed to be seen. The patient requested to speak to Nurse A in private and expressed having problems with pain and feeling suicidal. Nurse A told us that she escorted the patient to the nurse's station and assigned a nursing assistant (NA) to stay with him. Nurse A, who was working with a critically ill patient, reported communicating to the NA that the patient was suicidal and asked her to relay that information to another registered nurse (Nurse B). Nurse A did not document the patient's complaint of suicidality or instructions to the NA in the medical record.

Nurse B told us that the patient initially seemed hesitant to talk, but stated that he wanted to see a physician. As the patient presented to the medical center with a significant MH concern, Nurse B evaluated the patient for suicidal ideation per policy using the approved two-question suicide risk screen: (1) Are you feeling hopeless about the Present/Future? and (2) Have you had any thoughts about taking your life? An affirmative response to both questions or an affirmative response to the second question triggers a full suicide risk assessment.

The patient responded "yes" to the first question, but "no" to the second question, which resulted in a negative suicide screen. Nurse B asked him why he was wearing his combat attire, to which he responded, "To show I'm a combat vet." Staff reported that the patient had worn military attire to the medical center in the past, but had not worn his full combat uniform before. Nurse B told us he checked the patient's duffle bags but did not see any weapons. Nurse B also told us he used various interview techniques to ask the patient about suicidality and homicidality, which he repeatedly denied. Nurse B's progress note, which covered a 3 hour period., reflects that the patient was assigned a triage level 2[7] (indicating his high risk status). Nurse B suggested that the NA stay with the patient for support while awaiting the ED physician and instructed her to move the patient closer to the nurse's station once a bed became available.

Approximately 1 hour later, the ED physician, who had involuntarily admitted the patient on a previous visit, assessed the patient. The patient stated that he wanted treatment for his pain, which he rated as a "3" out of 10. He also expressed worry about becoming addicted to pain medication. The ED physician noted that the patient presented with

[7] The Emergency Severity Index (ESI) is a five-level ED triage algorithm that provides clinically relevant stratification of patients into five groups from 1 (most urgent) to 5 (least urgent) on the basis of acuity and resource needs. Level 2 denotes a high risk such as a suicidal or homicidal patient. US Department of Health and Human Services: Agency for Healthcare Research and Quality. http://www.ahrq.gov/research/esi/esi1.htm

"severe depression and pain issues," and had taken several pain pills over a 2-week period. The patient was crying, but he denied suicidal or homicidal ideation. The ED physician felt that admission was appropriate, and the progress note reflects that the patient agreed to voluntary admission to an inpatient MH unit. The ED physician consulted the on-call psychiatrist who accepted the patient for admission. Documentation reflects the patient was to be admitted for mental health conditions including depression and PTSD."

The patient was moved to a bed directly in front of the nurse's station, given intramuscular injections of an NSAID for back pain, and given an antiemetic for nausea. He was assigned a new triage level of 3.[8] The ED evaluation also included blood work and a urine toxicology screen. Per medical center policy for inpatient admissions, Nurse B asked the patient to put on hospital pajamas and provide a urine specimen, but he (the patient) was unable to void at the time and resisted changing clothing. Nurse B did not communicate this information to the ED physician but did document it in the medical record.

About 10 minutes after having received the medications, staff observed the patient leaving the ED. Nurse B reported asking the patient "Are you going home?" to which the patient replied "yes." Nurse B reported asking, "Are you ok?" to which the patient also replied "yes."

The ED physician told us that he was not informed the patient left the ED until after he (the patient) was already gone. He also stated that at the time, he did not feel the patient met criteria for involuntarily admission and that the patient denied suicidal ideation.

Approximately 3 hours later, the patient shot himself twice on the grounds of the medical center. The post-mortem toxicology found the presence of several prescribed and non-prescribed medications and pharmacologic substances. The autopsy report ruled the manner of death as suicide.

Inspection Results

Issue 1: Adequacy of Ongoing Medical and Mental Health Treatment

Treatment of Patient's Chronic Back Pain

Overall, we found that the FCPCP prescribed appropriate treatments and medications in an effort to control the patient's pain and that he (the patient) received routine pain

[8] This ESI triage level indicates that the patient has stable vital signs and no other factors that would meet high-risk criteria.

screenings according to VHA guidelines.[9] The FCPCP followed the patient from December 2008 through March 2010 and typically scheduled him for follow-up visits every 4 weeks. The FCPCP reported treating the patient's pain "conservatively," prescribing non-pharmacologic (local heat application, stretches, TENS[10] unit) and pharmacologic treatments (NSAIDs, topical anesthetics, opioids, and muscle relaxants). Per policy, the patient signed a pain management agreement in September 2009 that outlined provider and patient responsibilities related to opiate analgesic (narcotic) pain medication. The contract also stated that the patient was to continue follow-up with the PCP for pain management. In spite of the various pain treatments offered, the patient continued to have chronic pain. The FCPCP referred the patient to the Polytrauma/Pain Clinic on February 3. Clinic staff made repeated and unsuccessful attempts to contact the patient; he was ultimately scheduled for early March but he missed the appointment. Follow-up attempts to reschedule his appointment were in process at the time of his death.

Treatment for Patient's MH Diagnoses

We found that the patient received reasonable care for his MH diagnoses. The patient saw his MH psychiatrist and the MH nurse practitioner seven times between January 2009 and March 2010. During this time, he was treated for his MDD and PTSD with trials of medications including antidepressant, anti-anxiety, and sleep medications. The patient reported that his pain caused him to be depressed, but he would often discontinue his psychotropic medications and reported little consistent benefit from the prescribed medication.

The patient had three admissions to the MH unit for suicidal ideation, and each time was assessed to be at moderate or low risk for suicide. The patient was consistently contacted post-discharge in accordance with VHA requirements.

The FCPCP also referred him for individual MH therapy, but the patient repeatedly declined. He was referred to, but did not attend, the OEF/OIF support group and orientation classes for group therapy. The patient completed the PTSD program at the Martinsburg VAMC.

The Freedom Center CM provided supportive case management services to the patient, and given the complexity of the patient's medical and psychosocial issues, made appropriate inquiries to secure more intensive case management services on his behalf.

[9] VHA Directive 2009-053, *Pain Management*, October 28, 2009.
[10] Transcutaneous Electrical Nerve Stimulation units are predominately used for nerve related pain conditions (acute and chronic). It works by sending stimulating pulses across the surface of the skin and along the nerve strands. http://www.tensunits.com

However, the patient did not meet all the criteria[11] for the Mental Health Intensive Case Management (MHICM)[12] program.

Issue 2: ED Care Prior to Suicide Event

We found that the patient received reasonable care in the ED during the hours preceding his suicide. The ED staff screened the patient for suicide risk and took actions to promote his safety. While Nurse A failed to appropriately document the positive suicide screening results, she did assign an NA to stay with him. Nurse B also completed a suicide screen, the results of which were negative. Nurse B asked the NA to stay with the patient, moved him closer to the nurse's station, and checked his duffel bag for weapons. The physician evaluated the patient timely (within about 1 hour 15 minutes of his presentation to the ED), and ordered pain medication and an antiemetic for nausea. While the patient denied suicidality, the ED physician believed the patient would benefit from hospitalization and arranged to admit him to the inpatient MH unit. The patient initially accepted voluntary admission, but left the ED before it could be completed.

We noted that there were communication lapses during the hours leading up to the patient's departure from the ED. We received conflicting reports regarding the content and relay of the patient's information between Nurse A, the NA, and Nurse B. At the time of assessment, the ED physician did not feel that the patient met commitment criteria and was competent to make decisions. Additionally, the patient repeatedly denied suicidal ideation to him and Nurse B. However, the ED physician lacked information regarding the patient's verbalized suicidal ideation to Nurse A, resistance to change clothing, and failure to provide a urine specimen. Although this information may not have changed the ED physician's assessment, or influenced whether the patient would meet the criteria for involuntary admission, it nevertheless should have been communicated. Nurse B told us that he did not relay that information to the ED physician because, "It was a situation call and in most cases doesn't change the plan of care." In addition, he stated that the ED providers were also managing several critically ill patients that night. Our review of the ED log confirmed this assertion.

Proper hand-off communication ensures the exchange of relevant patient information between providers. According to local medical center policy, "The information communicated during the hand-off must be accurate and allow the opportunity to ask and respond to questions. When patients are assessed as high risk, i.e. falls, elopement, violence, medications (insulin, heparin) etc, the receiving care provider must be informed."

[11] Criteria for MHICM includes: Diagnosis of severe and persistent mental illness; severe functional impairment; inadequately served; high hospital use; and clinically appropriate for outpatient status.
[12] VHA Directive 2006-004, *VHA Mental Health Intensive Case Management (MHICM).* January 30, 2006.

Issue 3: Other Issue - Required VHA Training

We also reviewed the training records of all staff assigned to the ED and found that six out of seven ED physicians had completed the *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*. Specifically, the ED physician, Nurse A and Nurse B all had the required training. However, 10 of 15 other ED physicians (residents and attending physicians) did not have the training. VHA policy[13] requires that all health care providers, including physicians, psychologists, registered nurses, social workers, physician assistants, pharmacists and dentists must complete the training. The Chief of Primary Care acknowledged that he was aware of the deficiencies.

Conclusions

We found that the ED staff made reasonable efforts to provide treatment to the patient in the hours preceding his suicide. In addition, we found that the patient received ongoing primary care and MH services, and providers made appropriate efforts to manage the patient's pain and treat his MH conditions from August 2008 to April 2010. However, we found opportunities for improvement in the areas of communication (hand-off and intra-staff) and suicide risk management training.

Recommendations

Recommendation 1. We recommend that the VISN Director ensure that the Medical Center Director requires providers to optimize appropriate "hand-off" and intra-staff communication.

Recommendation 2. We recommend that the VISN Director ensure that the Medical Center Director requires clinical staff complete the mandatory suicide risk management training.

[13] VHA Directive 2008-051. *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, August 28, 2008.

Comments

The VISN and Medical Center Directors agreed with the findings and recommendations and provided acceptable action plans. The Medical Center Director will ensure all providers review the "Hand-off Communications" Medical Center Policy and reinforce the importance of the hand-off communication processes. The Medical Center Director will also ensure that all required clinicians have completed the suicide risk management training by October 31, 2010. We will follow up until the planned actions are completed.

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

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 7, 2010

From: VISN Director

Subject: **Healthcare Inspection – Suicide After an Emergency Department Visit, Dayton VA Medical Center, Dayton, OH**

To: Assistant Inspector General for Healthcare, Office of Inspector General

Please find attached the comments from the Medical Center Director, VA Medical Center Dayton, Ohio, on pages 11-13.

(original signed by:)

Jack G. Hetrick, FACHE

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: October 7, 2010

From: Medical Center Director

Subject: **Healthcare Inspection – Suicide After an Emergency Department Visit, Dayton VA Medical Center, Dayton, OH**

To: Network Director, VA Healthcare System of Ohio, VISN 10 (10N10)

Please find attached our comments regarding the Healthcare Inspection of the Dayton VA Medical Center on pages 12-13.

Guy B. Richardson, MHSA, FACHE

Director's Comments to Office of Inspector General's Report

The following Director's comments are submitted in response to the recommendations in the Office of Inspector General's report:

OIG Recommendations

Recommendation 1. We recommend that the VISN Director ensure that the Medical Center Director requires providers to optimize appropriate "hand-off" and intra-staff communication.

Concur **Target Completion Date:** October 31, 2010

A review of the facility policy on Hand-Off Communications was performed by the Patient Safety Manager to assure the policy provided appropriate content and direction to address hand-off and intra-staff communication. The policy was found to be current and adequate for this purpose. All providers will review "Hand-off Communications" Medical Center Policy 008Q-11 by October 31, 2010. The Medical Center policy will be reviewed during the October Clinical Executive Board and the Quarterly Medical Staff Meeting to provide reinforcement of the importance of the hand-off communication processes.

Recommendation 2. We recommend that the VISN Director ensure that the Medical Center Director requires clinical staff complete the mandatory suicide risk management training.

Concur **Target Completion Date:** October 31, 2010

A facility wide assessment was completed to identify all clinical staff requiring the Mandatory Suicide Risk Management Training based on VHA Directive 2008-151 Mandatory Suicide Risk and Intervention Training for VHA Healthcare Providers. All required clinicians will have this training completed in LMS by October 31, 2010. The training requirement will be added to all new appropriate clinical staff members LMS mandatory training plan to ensure completion of the training within 90 days of entering the position.

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	Tishanna McCutchen, MSPH, MSN Atlanta Office of Healthcare Inspections (404) 929-5981
Acknowledgments	Michael Shepherd, MD Victoria Coates, MSW, MBA

Appendix D

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