Administrative Closure
Quality of Care and Discharge Planning Issues
Martinsburg VA Medical Center, Martinsburg, West Virginia
(2008-02868-HI-0180)

12/3/08 - Please close as admin closure.

Purpose: The Department of Veterans Affairs, Office of Inspector General, Office of Healthcare Inspections, reviewed allegations regarding inappropriate treatment, insufficient social services, and environmental safety issues. The purpose of the review was to determine whether the allegations had merit.

Background: The complainant is a (b)(6) male with a history of Post Traumatic Stress Disorder, depression, chronic pain, bladder dysfunction, and spinal injury as a result of a motor vehicle accident while on active duty. He was admitted (b)(6) to Martinsburg VAMC (VAMC), through the Emergency Department to a locked inpatient psychiatric unit, with complaints of depression and suicidal thoughts. He has a history of multiple suicide attempts.

The complainant contacted the OIG Hot Line Division alleging that:

1. While an inpatient, he was never evaluated by a mental health professional.
2. The psychiatric unit was not handicap accessible and as a result he fell in the shower and injured himself. He requested medical attention for his injuries but received none.
3. He was placed on suicide precautions, denied anything to drink, did not receive help in changing his soiled diapers, and all his clothes including his prosthetic shoe and brace were removed.
4. He was discharged to a mission without ID or money.

Issue 1: (b)(6) alleged that while a patient on the psychiatric unit, he was never seen by any mental health professionals to discuss his suicidal thoughts and was isolated in his room. Our review of the medical record showed that (b)(6) was evaluated throughout his stay by psychiatrists, psychiatric social workers, and nursing staff. He was checked every 15 minute for safety and the observations were documented. He participated in community meeting groups and journaling groups, as well as attending a wellness group with the clinical social worker and Local Recovery Coordinator. We found that (b)(6) discussed in detail his suicide thoughts, plans, and history with his providers and his treatment plan reflected that interaction.

Issue 2: (b)(6) alleged that the locked psychiatric unit was not handicapped accessible. VHA National Center for Patient Safety has issued standards for identifying and correcting environmental safety concerns on locked mental health units in order to prevent inpatient suicide and suicide attempts. The psychiatric unit must meet heightened safety standards; adaptive devices for handicap accessibility would not meet these safety standards. (b)(6) history of multiple suicide attempts and documented statements made by the complainant that "he wants to be admitted on a secure unit because he doesn't trust himself" and that "he would rather die than live right now" placed him at High Risk for suicide. Admission to a locked psychiatric unit was an appropriate plan for this patient.

(b)(6) fell in the shower on (b)(6) but did not tell staff until the next day during the community meeting. He complained of pain in his left shoulder and thigh but no injuries were noted. (b)(6) examined the patient and ordered a cervical spine x-ray, which was negative, and ordered an ice pack. Examination showed the patient had use of his arms bilaterally with out trouble or pain. On (b)(6) the complainant was informed by his treatment team that he would be discharged home. He became agitated and demanded to speak to the patient advocate stating "I'm suicidal, I'm going to blow my head off when I leave here, and they are sending me home". The treatment team was informed and an order for suicide precautions was given; the complainant was placed in an observation room. Later that day the patient complained of "paralysis" in his left hand. He was examined by an emergency department physician who ordered an x-ray. The physician documented "no evidence of a central nervous system process; supportive therapy as needed." We concluded that the complainant was appropriately evaluated and treated for his injuries.

Issue 3: (b)(6) alleged that (b)(6) was placed on suicide precautions he was denied anything to drink, left in soiled diapers, and his clothes including his prosthetic shoes and braces were removed. (b)(6) stated he felt suicidal on the day of his proposed discharge (b)(6) The nurse documented that the patient was placed on suicide precautions and moved to an observation room. His clothes were removed, he was searched, and the reasons for these actions were explained to him. He was given paper gowns with paper linens for his bed. While on suicide precautions, he was checked hourly to ensure that fluids were at his bedside, meals were served and consumed, and although he was not allowed to shower for safety reasons, he was assisted with activities of daily living including hygiene. We did not substantiate the allegations.

Issue 4: (b)(6) alleged (b)(6) discharged from the psychiatric unit to a Rescue Mission, in Hagerstown, MD, without ID or money. The VAMC social worker's documentation showed that transportation by VA car was scheduled to take the patient home if wife or family were home. Multiple attempts to contact the wife at home and on the cell phone were made without success. (b)(6) refused to allow the social worker to contact his parents or sister, so transportation by VA car was cancelled. (b)(6) (b)(6) requested discharge to the Mission which is handicap accessible. He was transported by the Red Cross wheelchair van. The choice to go to the Mission for short term and then home was noted in the psychiatry discharge note. The physician, nurse and social worker involved in his discharge respected the wishes of (b)(6) to be transported to the Mission and provided appropriate discharge instructions and support.

Summary:

We found no evidence to support the complainant's allegations, nor did we identify any issues requiring further review. We are closing this case administratively without issuance of a formal report.

Prepared by:

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December 1, 2008

Approved by:

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