Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Clinical and Administrative Issues in the Suicide Prevention Program Alexandria VA Medical Center Pineville, Louisiana

Report No. 11-02325-263 **August 30, 2011**

VA Office of Inspector General
Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections evaluated alleged mismanagement of clinical and administrative aspects of several Social Work Service (SWS) programs at the Alexandria VA Medical Center (the facility), Pineville, Louisiana. The confidential complainant was primarily concerned with management of the Suicide Prevention Program.

We found that in February 2009, the high risk for suicide list included more than 400 patients; however; this condition no longer existed at the time of our site visit. To comply with Veterans Health Administration requirements, managers revised systems to identify, track, and monitor patients at high risk for suicide.

We did not substantiate breaches in confidentiality or privacy on unit 9A, in the Mental Health Intensive Case Management office, or in the Suicide Prevention Program offices. We also did not substantiate that some SWS programs lacked management oversight or that SWS leaders did not act on complaints or follow up on peer reviews. We made no recommendations.

The Veterans Integrated Service Network and Facility Directors agreed with the report.

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

TO: Director, Veterans Integrated Service Network (10N16)

SUBJECT: Healthcare Inspection – Clinical and Administrative Issues in the Suicide Prevention Program, Alexandria VA Medical Center, Pineville, Louisiana

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections evaluated alleged mismanagement of clinical and administrative aspects of several Social Work Service (SWS) programs at the Alexandria VA Medical Center (the facility), Pineville, LA. The confidential complainant was primarily concerned with management of the Suicide Prevention Program (SPP). The purpose of the review was to determine whether the allegations had merit.

Background

This secondary care facility provides a broad range of inpatient and outpatient health care services. It operates 114 acute care and residential treatment program beds and 112 community living center beds. Outpatient care is also provided at three community based outpatient clinics in Lafayette, Jennings, and Natchitoches, LA. The facility is part of Veterans Integrated Service Network (VISN) 16 and serves a veteran population of over 100,000. It is one of three specialty referral facilities in the VISN for acute and intermediate psychiatric care.

SWS has 73.5 full-time employee equivalents assigned to multiple primary and specialty programs that include the SPP, Health Care for Homeless Veterans (HCHV), Community Residential Care, chemical dependency outpatient program (CDOP), palliative care, Home Based Primary Care, Contract Nursing Home, mental health, primary care, Operation Iraqi Freedom/Operation New Dawn, and Visual Impairment Services. In addition, SWS provides support services to 20 inpatient/outpatient programs.

Suicide Prevention Guidance

In 2005, the facility's policy[1] focused primarily on the identification of potentially suicidal patients and the need for suicide precautions, treatment planning, and special observation for high-risk, hospitalized patients. The policy did not include, nor did Veterans Health Administration (VHA) require, monitoring or follow-up actions after discharge.

In 2006, VHA implemented several initiatives aimed at suicide prevention, including establishing the National Suicide Prevention Center of Excellence, appointing a National Suicide Prevention Coordinator (SPC), establishing a suicide prevention hotline, developing a distinct patient record flagging system, and establishing SPPs in all VHA facilities.

In June 2007, the facility hired an SPC whose role was to track and report on patients determined to be at high risk for suicide, coordinate ongoing monitoring and enhancements in care, and provide community outreach and suicide prevention training.

In April 2008, the Principal Deputy Under Secretary for Health issued additional guidance[2] requiring the SPC to maintain "a list of patients at high-risk for suicide, including but not limited to, those who have suicidal ideation and those who survived suicide attempts, as well as others with high-risk behaviors." The PDUSH's memorandum also required that patients who were hospitalized "as a result of a high-risk for suicide ideation, must be placed on the high-risk list, and kept on the list for a period of at least 3 months after discharge." Patients placed on the high-risk list for other reasons would also require evaluation at least weekly for the next month.

In July 2008, VHA issued instructions[3] requiring the use of Patient Record Flags (PRF) as a means to communicate to other VA staff that a patient is on the high risk for suicide list, needs close follow-up, and should be contacted if he or she misses or cancels an appointment. The guidance mandates that SPCs and treatment team members evaluate PRFs every 90 days to "ensure that the PRF is promptly removed when the high risk status is resolved." In September 2008, VHA published a revised handbook[4] reiterating these requirements.

Facility policy, updated in January 2011,[5] states that when a PRF is inactivated, the Suicide Prevention Team may place the patient on the post-PRF "monitoring" list (referred to as the monitoring list in the remainder of this report). Patients will then be monitored for no-show appointments, and will receive letters and/or will be contacted.

[1] Medical Center Memorandum 11-41, *Suicide/Suicidal Behavior*, May 13, 2005.
[2] PDUSH memorandum, Patients at High-Risk for Suicide, April 24, 2008.
[3] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at Risk for Suicide*, July 18, 2008.
[4] VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics, September 11, 2008.
[5] Medical Center Memorandum 116-2, *Suicide Prevention, Intervention and Management*, January 7, 2011.

This monitoring list is not mandated by VHA; rather, facility leaders implemented this list as an additional safety measure for patients that no longer met the strict high-risk criteria but could still benefit from regular monitoring and staff contacts. As such, the facility maintains two lists: the PRF (high-risk) list and the (post-PRF) monitoring list.

In April 2011, a confidential complainant alleged that:

- There were more than 600 patients on the "high risk for suicide" list, and that they were not being monitored as required.
- Confidentiality and privacy were being breached in several program areas, including the suicide prevention case managers' offices.
- SWS leaders were not providing adequate oversight of programs as:
    - Program managers were not being properly supervised.
    - SPP program managers and staff did not receive necessary training.
    - SPP standard operating procedures (SOPs) were non-existent.
- SWS leaders were not responsive to complaints and did not appropriately address peer review findings.

The complainant also cited personnel-related issues that were outside of OHI's purview and are not addressed in this report.

Scope and Methodology

We conducted a site visit May 17–19, 2011. Prior to our visit, we reviewed facility and VHA policies, directives, and handbooks; select patients medical records; quality assurance documents; VA police, patient advocate, and privacy tracking reports; staff training records; and the American Psychiatric Association guideline on suicide assessment and prevention. While onsite, we interviewed Service chiefs; the SPP, HCHV, and CDOP coordinators, case managers, and program support clerks; and other clinical and administrative staff knowledgeable about the issues. In addition, we toured the inpatient mental health unit (9A), Mental Health Intensive Case Management (MHICM) office, and the relevant SWS program offices.

This review was performed in accordance with *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Inspection Results

Issue 1: Patient Monitoring

While we could not substantiate that there were more than 600 patients on the high risk for suicide list, we did find that the list included more than 400 patients in February 2009. However, facility managers had already taken corrective actions and the condition no longer existed at the time of the complaint in April or during our visit in May 2011. Facility and program managers hired two SPP case managers in March 2009; re-evaluated patients for inclusion on the PRF list and eliminated those that did not meet the stricter VHA-mandated criteria; and implemented the monitoring list for those patients that no longer met criteria for being at high risk for suicide but could benefit from regular monitoring and staff contacts. On May 17, 2011, the facility's PRF and monitoring lists included 23 and 20 patients, respectively.

We could not fully evaluate the allegation that some high-risk patients were not adequately monitored. Prior to VHA Handbook 1160.01, little guidance existed on how, and at what frequency, high-risk patients should be monitored. We therefore did not have clear criteria by which to evaluate "monitoring" compliance prior to October 2009.

We reviewed a sample of patients who attempted or completed suicide after October 1, 2009, when VHA mandated PRFs and defined the monitoring requirements. According to data provided by the SPC, there were 57 suicide attempts and 2 completed suicides from October 2009 through March 2011. Six of the 57 patients were on the PRF list at the time of the attempt, as were both of the patients who completed suicide. The SPC told us that a large majority of the remaining 49 patients were not known to be at risk and were placed on the PRF list after their suicide attempt. We reviewed the medical records of the eight PRF-listed patients and found that in all cases, the patients were generally monitored in accordance with guidelines. We also reviewed the medical records for 10 of the 33 patients on the PRF list as of April 27, 2011, and found that clinicians complied with current monitoring and follow-up requirements the patients were generally monitored in accordance with guidelines. We also reviewed the medical records for 10 of the 33 patients on the PRF list as of April 27, 2011, and found that clinicians complied with current monitoring and follow-up requirements.

We found that the revised systems to identify, track, and monitor patients at high risk for suicide met VHA requirements.

Issue 2: Confidentiality and Privacy

We did not substantiate breaches in confidentiality or privacy on unit 9A, in the MHICM office, or in the SPP offices. Specifically, the complainant alleged that:

- In some areas, several staff members shared office space.

- On unit 9A, clinical staff conducted interviews and assessments in an open area that did not assure auditory privacy.

While we confirmed that a SPP case manager and the SPP program assistant did share an office, this arrangement did not compromise patient confidentiality or privacy as they did not meet with patients in this area.

On unit 9A, we found an area described by staff as "the fishbowl"— a glass-enclosed meeting/office space central to the unit where staff conducted interviews and assessments. We also found several other private offices and conference rooms that were available for meetings and interviews. All of these rooms offered auditory privacy. During our tour, we saw a non-private patient/family waiting room adjacent to "the fishbowl;" however, staff advised that this room is not used for private interviews or meetings.[6]

The SPC and the facility's privacy officer both told us they were unaware of any confidentiality or privacy concerns. Further, a query of the privacy violation tracking system from 2008 to present produced no reports related to this matter.

We found that unit 9A, the MHICM offices, and the SPP offices all afforded patient-clinician confidentiality and privacy as long as staff used the spaces responsibly.

Issue 3: Management Oversight

We did not substantiate that some SWS programs lacked management oversight. The examples provided by the complainant did not support the allegations.

Staff supervision. We did not substantiate that some SWS program managers were not properly supervised. We interviewed the SPP, HCHV, and CDOP program coordinators,[7] all of whom reported that SWS leadership provided appropriate support and guidance.

We also determined that SWS leaders made appropriate efforts to ensure communication between and among the SPP staff, SWS program managers, and other clinical programs and staff. The Chief of Mental Health Service told us that he interacts daily with SWS leaders to ensure there is continuity between the two Services. Interdisciplinary teams held daily morning meetings to discuss mental health inpatients and new admissions. The SPP team also meets daily to review the admission list from the previous night and the status of patients on the PRF and monitoring lists. The SPP team sends a daily email

[6] The CDOP temporary space, which was located in a different building but was nonetheless a concern to some staff, did not consistently afford confidentiality and privacy because counselors had to share offices until renovations to their unit were completed. Facility managers were aware of the condition and action plans were in place.
[7] The SPP, HCHV, and CDOP coordinators were specifically mentioned by the complainant as lacking supervision.

(referred to as the "4-2" list) to the mental health interdisciplinary team members to ensure continuity of safety measures and treatment planning for high-risk patients.

Staff training. We did not substantiate that SPP program managers and staff did not receive the necessary training. We reviewed the training records for the program managers, case managers, and clerks and found that all staff had completed training required for their program areas and job functions.

SOPs. We did not substantiate that there was a lack of SPP-specific SOPs.

The facility's policy[8] is a comprehensive document that includes detailed information about the SPP; staff responsibilities for various elements of the policy; suicide risk assessment and safety planning requirements; placement of PRFs; and requirements and intervals for monitoring of patients on the PRF and monitoring lists. We also found separate SWS policies addressing professional practice standards.

VHA has issued substantial guidance related to SPP operations and expectations, and these resources are also readily available for reference.

Issue 4: SWS Leaders' Responsiveness

We did not substantiate that SWS leaders did not act on complaints.

Patient complaints. As this allegation lacked specificity, we reviewed patient advocate reports involving mental health patients from July 2008–May 2011 for which social workers were a part of the care team. There were four patient complaints lodged during this time, all of which were related to staffing issues in the CDOP program. SWS leaders were aware of the concerns and took interim actions to address the condition.

Staff complaints. The complainant also alleged that SWS leaders did not respond to staff complaints about program managers and their alleged improper actions. The examples provided by the complainant were personnel-related, rather than patient care-related, and therefore fell outside of our purview. However, we interviewed SWS leaders and selected program coordinators to determine the process by which they would respond to concerns brought by staff members. Interviewees uniformly stated that they would listen to the concern and seek guidance from Human Resource Service for personnel-related issues, or would discuss program or patient-related concerns with the appropriate Service chief or program manager. We noted that in personnel-related cases, managers typically do not provide feedback to complainants due to privacy laws.

Peer reviews. We did not substantiate the allegation that SWS leaders did not appropriately address peer review findings. The complainant cited three cases in support

[8] MCM 116-2, *Suicide Prevention, Intervention and Management*, January 7, 2011

of the allegations; however, only one of the cases involved peer review of a social worker's practice. The other two peer-reviewed cases involved other clinical disciplines in non-SWS programs; therefore, the SWS leaders would not be responsible for providing feedback or otherwise following up on findings.

We reviewed the one applicable peer-reviewed case and did not find evidence that SWS leaders attempted to minimize the findings or otherwise failed to take actions, as alleged. In October 2008, a patient was placed on the monitoring list. At that time, he contracted for safety and was given a follow-up appointment in 3 months. The patient did not return to the mental health clinic as scheduled, and there was no apparent attempt to contact the patient about his missed appointment. Approximately 1 year later, the SPP learned that the patient died of a self-inflicted gunshot wound 28 days after he was placed on the monitoring list (in October 2008). Because peer reviews are non-punitive, actions typically focus on providing feedback to the clinician, discussing lessons learned so that other providers can avoid similar problems, and improving processes that can help minimize the possibility of human error. We found that in this case, SWS leaders did follow-up on the peer review findings, communicated lessons learned to the SWS staff, and implemented procedural changes to more effectively identify and monitor patients at high risk for suicide.

We also reviewed SWS-related peer reviews completed between 2008 and May 2011. The Peer Review Committee minutes reflected that SWS leaders reviewed the SWS-related peer reviews and provided feedback to the Committee. SWS leaders and program managers also told us that SWS leaders discussed lessons learned related to peer review findings during staff meetings.

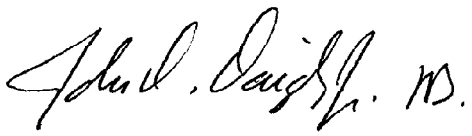
Conclusions

In February 2009, the high risk for suicide list included more than 400 patients; facility managers had already taken corrective actions and the condition no longer existed at the time of our site visit. Revised processes met VHA requirements for tracking and monitoring of high-risk patients.

We did not substantiate breaches in confidentiality or privacy on unit 9A, in the MHICM office, or in the SPP offices. We also did not substantiate that some SWS programs lacked management oversight or that SWS leaders did not act on complaints or follow up on peer reviews. We made no recommendations.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the report. We made no recommendations and plan no further actions.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Appendix A

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 10, 2011

From: Network Director, South Central VA Health Care Network (10N16)

Subject: **Healthcare Inspection – Draft report, Clinical and Administrative Issues in the Suicide Prevention Program, Alexandria LA**

To: Director, Operations Division, Office of Management and Administration (53B)

Thru: Director, VHA Management Review Service (10A4A4)

1. I have reviewed the draft report from the OIG and concur with the content of the report titled, Clinical and Administrative issues in the Suicide Prevention Program, Alexandria VA Medical Center.

2. If you have any questions contact, Mary Jones at 601-206-6974.

(*original signed by for and in the absence of*:)
George H. Gray, Jr.

Appendix B

Medical Center Director Comments

Department of Veterans Affairs **Memorandum**

Date: August 8, 2011

From: Medical Center Director (502/00), VAMC, Alexandria, LA

Subject: **Draft report, Clinical and Administrative Issues in the Suicide Prevention Program, Alexandria LA**

To: Network Director (10N16), South Central VA Health Care Network

1. We have reviewed the draft report from the OIG.

2. The Medical Center concurs with the content of the report titled, Alexandria VA Medical Center.

3. If you have any questions contact, Portia McDaniel, Chief, Performance Improvement at (18) 466-2370.

(original signed by:)
Gracie Specks, MS, MBA

Appendix C

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720
Acknowledgments	Victoria Coates, LICSW, MBA Karen Sutton, BS Darlene Conde-Nadeau, NP Michael Shepherd, MD

Appendix D

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