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OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inadequate Care of a Patient Who Died by Suicide on a Medical Unit at the Sheridan VA Medical Center in Wyoming

Healthcare Inspection | **23-03159-204** | **July 25, 2024**

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Sheridan VA Medical Center (facility) in Wyoming to assess an allegation of inadequate clinical care of a patient who died by suicide on the inpatient medical unit (medical unit). The OIG substantiated that clinical staff did not provide adequate care to manage the patient's suicidal ideations. Specifically, clinical staff did not adhere to policies or standard operating procedures (SOPs) related to suicide risk assessments and evaluations, documentation and communication, and environmental safety. The OIG did not determine that clinical staff provided inadequate care to manage the patient's alcohol withdrawal. The OIG also reviewed an additional concern related to facility leaders' response and found that facility leaders evaluated and addressed the patient's suicide in accordance with Veterans Health Administration (VHA) policy.[1]

Patient Case Summary

On day 1, a facility medical officer of the day (MOD 1) admitted the patient to the facility's medical unit, placed an order for one-to-one observation status (1:1) for suicidal ideation, started a Clinical Institute Withdrawal Assessment of Alcohol Revised (CIWA-Ar) protocol for medication treatment of alcohol withdrawal symptoms, and entered a consult to the psychiatry service.[2] The admitting nurse (Nurse 1) completed a Columbia-Suicide Severity Rating Scale (C-SSRS) with the patient and documented that the screen was positive.[3] A certified nursing assistant (CNA) conducted an inventory and hazardous item check of the patient's belongings, and documented that the patient was allowed to maintain possession of the clothes, belt, necklace, bracelet, cell phone, and wallet.[4] Nurse 1 documented "environmental risk check complete, hazardous items checked and removed from patient and room."

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[1] VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. The OIG reviewed the patient's electronic health record and facility documents and found that facility leaders ensured the completion of an institutional disclosure and peer review, in addition to a root cause analysis.

[2] American Society of Addiction Medicine, *Addiction Medicine Essentials, Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)*, supplement to ASAM News, Vol 16, No. 1, https://www.ci2i.research.va.gov/paws/pdfs/ciwa-ar.pdf. Providers use the CIWA-Ar protocol to measure and score alcohol withdrawal symptoms. Mild withdrawal has a score less than 8 and moderate withdrawal has a score between 8–15.

[3] The C-SSRS is an instrument to screen patients for suicide risk that utilizes eight questions with an option to answer "yes" or "no." A "yes" response to questions 3, 4, 5 or 8 will result in a positive screen. The patient answered "yes" to six of the eight questions, resulting in a positive screen. Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to the VISN Network Directors, VISN Chief Medical Officers, VISN Chief Mental Health Officers, and Medical Center Directors, November 23, 2022.

[4] Hazardous items are defined as "objects that constitute a threat to the safety of patients and staff and/or the security of the unit." Facility SOP 118-38, "Hazardous Item Checks," August 24, 2021.

On day 2, a MOD (MOD 2) documented that the patient remained on 1:1 pending the psychiatrist's evaluation and was undergoing alcohol withdrawal treatment using medications. At approximately 4:00 p.m., the psychiatrist performed a telemental health evaluation of the patient and documented "no evidence of imminent harm to self or others" and "is currently a LOW short term risk" (for completing suicide) with "no clear imminent risk of suicide," but did not sign the note for approximately 25 hours.[5] On day 3, MOD 2 completed an evaluation and noted the patient was still receiving medications for active alcohol withdrawal symptoms and despite denying suicidal ideations, remained on 1:1. That afternoon, the psychiatrist discontinued the 1:1 order without reassessment and placed the patient on checks every 15-minutes.

On day 4, a MOD (MOD 3) documented the patient was found at 2:45 a.m. in the bathroom hanging from the necklace attached to a ceiling lift.[6] At 3:21 a.m. MOD 3 pronounced the patient dead.

Inadequate Clinical Care of the Patient Prior to Suicide

The OIG found that the psychiatrist did not reassess the patient as required when making the decision to change 1:1 to checks every 15 minutes. The psychiatrist told the OIG that the 1:1 was changed on day 3 due to the previous day's assessment and that the patient was not suicidal.

The OIG found that the psychiatrist did not sign the telemental health evaluation note within the required 24-hour time frame thus leaving their assessment unviewable to MOD 2.[7] MOD 2 stated that had the psychiatric evaluation note been available, a conversation with the psychiatrist would have occurred to convey the opinion that checks every 15 minutes were not adequate in the medical unit and to suggest moving the patient to an acute psychiatric unit. The psychiatrist acknowledged to the OIG that awareness of the MOD's opinion "would have definitely helped."

The OIG found that Nurse 1 did not complete a warm handoff to a licensed independent practitioner for completion of the Comprehensive Suicide Risk Evaluation (CSRE) after the

[5] An unsigned note is not available to other providers.

[6] VHA Healthcare Environment and Facilities Programs (HEFP) Enterprise Support Service, "Safe Patient Handling and Mobility Guidebook," http://vaww.hefp.va.gov/sites/default/files/files/2023-05/SPHM%202022.pdf. (This website is not publicly accessible.) A ceiling lift is a full body lifting device used to move patients out of beds, into and out of chairs, or for repositioning. The lift is mounted to the ceiling on an overhead track for accessibility and ease of use.

[7] The psychiatrist told the OIG that the telemental note was not signed within 24 hours due to the need for chart review, dictation, and note edits.

positive C-SSRS as required due to being unaware of the expectation to complete a warm handoff.[8]

The psychiatrist reported not having awareness that the C-SSRS was positive and that a CSRE was required. The OIG found that the psychiatrist did not complete the required CSRE. Although not documented, the psychiatrist stated all elements of the CSRE were considered during the telemental health evaluation on day 2, and remained confident in the determination that the patient was low risk for suicide.

The OIG found that staff did not remove the patient's belongings or reduce environmental risks to the greatest degree possible.[9] The CNA reported to the OIG that a decision was made with Nurse 1 to permit the patient to maintain possession of all belongings (minus a cellphone charger). The necklace and bracelet were specifically allowed due to sentimental value expressed by the patient. Despite clear guidance in facility policy, Nurse 1 reported being less concerned about removing belongings because the patient was on 1:1.[10]

There was also a failure to remove environmental risks from the patient's room in a manner consistent with facility policy.[11] The CNA stated that because the patient was on 1:1, nothing was removed from the room. Nurse 1 documented that an environmental risk check was completed; however, in an interview with the OIG stated, "I failed to verify everything." Staff should have mitigated the environmental risks to the greatest degree possible, regardless of the 1:1 observation status.

The OIG found that nursing staff documented the CIWA-Ar assessments every 1–4 hours and administered the lorazepam as ordered except for one error.[12] The medical unit nurse manager reported addressing the error with Nurse 1, and the OIG determined that the error had no impact on the patient's outcome.[13]

[8] RISK ID, Suicide Risk Identification, "VA Comprehensive Suicide Risk Evaluation (CSRE) Printable Worksheet," Appendix B, accessed August 8, 2023, https://www.mirecc.va.gov/visn19/cpg/recs/3/. The CSRE is an assessment tool that includes factors that indicate a patient's suicide risk level and assists licensed independent practitioners in developing a plan that mitigates a patient's risk for suicide. MOD 1 reported to the OIG an awareness that the patient was suicidal, entry of a psychiatry consultation, and an expectation that the psychiatrist would complete the CSRE; Facility SOP 116-05, "Identification and Management of Suicidal Behavior," November 18, 2020.

[9] Facility SOP 116-05.

[10] Hazardous items are defined as "objects that constitute a threat to the safety of patients and staff and/or the security of the unit." Facility SOP 118-38.

[11] Facility SOP 116-05.

[12] Nurse 1 administered 2 milligrams instead of 1 milligram of lorazepam as ordered.

[13] The OIG also determined that the medication error had no adverse impact to the patient.

Facility Leaders' Response to the Patient's Suicide

The OIG found that facility leaders evaluated and addressed the patient's suicide through the use of a variety of follow-up actions, including a root cause analysis, in accordance with VHA policy.[14] The facility's action plans addressed concerns identified in this report.

The OIG made four recommendations to the Facility Director related to clinical screenings and evaluations, reassessment of patients before removing 1:1 observation, timely documentation, and removing personal belongings and environmental risks for suicidal patients.

VA Comments

The Veterans Integrated Service Network and Facility Directors concurred with the findings and recommendations and provided acceptable action plans (see appendixes A and B). The OIG will follow up on the planned actions until they are completed.

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[14] VHA Directive 1050.01. The OIG reviewed the patient's EHR and facility documents and found that facility leaders ensured the completion of an institutional disclosure and peer review, in addition to the RCA.

Contents

Abbreviations

CIWA-Ar	Clinical Institute Withdrawal Assessment of Alcohol Revised
CNA	certified nursing assistant
CSRE	Comprehensive Suicide Risk Evaluation
C-SSRS	Columbia-Suicide Severity Rating Scale
EHR	electronic health record
LIP	licensed independent practitioner
MOD	medical officer of the day
OIG	Office of Inspector General
RCA	root cause analysis
SOP	standard operating procedure
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection at the Sheridan VA Medical Center (facility) in Wyoming to assess an allegation of inadequate clinical care of a patient who died by suicide on the inpatient medical unit (medical unit). The OIG evaluated a related concern regarding facility leaders' response to the patient suicide.

Background

The facility is part of Veterans Integrated Service Network (VISN) 19 and includes five community-based outpatient clinics, and two telehealth outreach clinics. The Veterans Health Administration (VHA) classifies the facility as a level 3 complexity.[1] As of January 2023, the facility had 10 inpatient medical, 20 acute psychiatric, and 115 Mental Health Residential Rehab Treatment Program beds. However, available beds were temporarily reduced to 7 medical, 12 acute psychiatric, and 40 Mental Health Residential Rehab Treatment Program beds.[2]

Allegations and Related Concerns

In June 2023, the OIG received two complaints that included an allegation of a patient receiving inadequate clinical care prior to completing suicide in the medical unit at the facility.[3] The Office of Healthcare Inspections identified concerns related to the management of the patient's suicidal ideations and alcohol withdrawal. In July 2023, the OIG opened a hotline to analyze the allegation of inadequate clinical care, and a related concern regarding facility leaders' response to the patient's suicide.

Scope and Methodology

The OIG completed a site visit at the facility from September 26 through 28, 2023. Additional virtual interviews were conducted prior to and after the site visit.

The OIG interviewed facility senior leaders, service chiefs and supervisory staff, quality management staff, frontline clinical staff for the medical unit, and a telehealth psychiatry staff member.

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[1] VHA Office of Productivity, Efficiency and Staffing (OPES), "Facility Complexity Model Fact Sheet," January 28, 2021. The VHA Facility Complexity Model categorizes medical facilities by complexity level based on patient population, clinical services offered, and educational and research missions. Complexity levels include 1a, 1b, 1c, 2, or 3. Level 1a facilities are considered the most complex and level 3 facilities are the least complex.

[2] The bed reduction occurred due to a nurse staffing shortage, and the reduction was in place at the time of the event. The OIG did not determine the reduction was a contributing factor to the patient's suicide.

[3] The OIG received the first complaint on June 16, 2023, through the Office of Accountability and Whistleblower Protection, and the second on June 20, 2023, from an anonymous source.

The OIG reviewed VHA and facility policies and standard operating procedures (SOPs) related to the care of patients with suicidal ideation and alcohol withdrawal management; external standards and literature reviews related to patient safety and communication; the patient's electronic health record (EHR); police and autopsy reports related to the patient's suicide; staff training records; and quality management reviews.

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 substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take place. The OIG is unable to determine whether an alleged event or action took place when there is insufficient evidence.

Oversight authority to review the programs and operations of VA medical facilities is authorized by the Inspector General Act of 1978, as amended, 5 U.S.C. §§ 401–424. The OIG reviews available evidence to determine whether reported concerns or allegations are valid within a specified scope and methodology of a healthcare inspection and, if so, to make recommendations to VA leaders on patient care issues. Findings and recommendations do not define a standard of care or establish legal liability.

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.

Patient Case Summary

The patient, a 40-year-old with a prior history of suicide attempts, was admitted with the diagnoses of posttraumatic stress disorder, substance abuse, alcohol dependence, anxiety disorder, bipolar disorder, and chronic pain.

During summer 2023, on day 1, county law enforcement brought the patient to a local community hospital in an intoxicated state after someone in the community called out of concern. According to the community hospital EHR, the patient was intoxicated with an alcohol level of 378 milligrams per deciliter and had been suicidal "for the past month."[4] Additionally,

[4] Evidence-Based Medicine Consult, "Lab Test: Ethanol (Ethyl Alcohol) Level," accessed on October 26, 2023, https://www.ebmconsult.com/articles/lab-test-ethanol-alcohol-level. Elevated blood alcohol concentration is associated with intoxication from drinking alcohol. In general, a blood alcohol level of 100 milligrams per deciliter to 300 milligrams per deciliter represents acute intoxication. Chronic alcoholics can commonly have levels greater than 300 milligrams per deciliter.

the patient reported a plan to attempt suicide by wrist laceration, a method used in a prior suicide attempt in early 2021.

A community hospital emergency room provider transferred the patient to the facility, at the patient's request, for treatment of alcohol withdrawal and active suicidality. A facility medical officer of the day (MOD 1) admitted the patient to the facility's medical unit, documented a plan for medication-assisted treatment of alcohol withdrawal symptoms, and entered a consult for psychiatry to evaluate the patient's suicidal ideation. MOD 1 documented in the EHR that the patient reported not taking psychiatric medications for "at least 6 months," drinking heavily for the past five days, and that "alcohol makes me suicidal." MOD 1 also documented a history of "chronic, severe substernal chest pain" from an accident that occurred six months prior. The patient reported to MOD 1 of refraining from drinking alcohol since 2019, and that the relapse was due to the desire to "numb the pain," referring to the substernal area. The EHR also included documentation that the patient had ongoing family issues, unemployment, and homelessness. MOD 1 placed the patient on one-to-one observation status (1:1), and ordered a Clinical Institute Withdrawal Assessment of Alcohol Revised (CIWA-Ar) protocol and medication to treat alcohol withdrawal symptoms.[5]

The admitting nurse (Nurse 1) completed a Columbia-Suicide Severity Rating Scale (C-SSRS) with the patient and documented that the screen was positive.[6] On admission, a certified nursing assistant (CNA) conducted an inventory and hazardous item check of the patient's belongings.[7] The CNA documented that the patient was allowed to maintain possession of the clothes, belt, necklace, bracelet, cell phone, and wallet. Nurse 1 documented "environmental risk check complete, hazardous items checked and removed from patient and room."

The next morning, day 2, the patient's family member called the nurse's station, spoke to a nurse (Nurse 2), and asked that the providers be made aware of the patient's "multiple suicide statements prior to admission" and that the patient "needs and deserves, additional, prolonged psychiatric care." Nurse 2 documented the conversation with the family member in a note that

[5] American Society of Addiction Medicine, *Addiction Medicine Essentials, Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar)*, supplement to ASAM News, Vol 16, No. 1, https://www.ci2i.research.va.gov/paws/pdfs/ciwa-ar.pdf. Providers use the CIWA-Ar protocol to measure and score alcohol withdrawal symptoms. Mild withdrawal has a score less than 8 and moderate withdrawal has a score between 8–15.

[6] The C-SSRS is an instrument to screen patients for suicide risk that utilizes eight questions with an option to answer "yes" or "no." A "yes" response to questions 3, 4, 5, or 8 will result in a positive screen. The patient answered "yes" to six of the eight questions resulting in a positive screen. Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation Update (Risk ID Strategy)," memorandum to the VISN Network Directors, VISN Chief Medical Officers, VISN Chief Mental Health Officers, and Medical Center Directors, November 23, 2022.

[7] Hazardous items are defined as "objects that constitute a threat to the safety of patients and staff and/or the security of the unit." Facility SOP 118-38, "Hazardous Item Checks," August 24, 2021.

was cosigned the same day by the MOD (MOD 2) and the on-call psychiatrist (psychiatrist).[8] MOD 2 documented that the patient remained on 1:1 pending the psychiatrist's evaluation and was undergoing alcohol withdrawal treatment using medications. At approximately 4:00 p.m., the psychiatrist performed a telemental health evaluation of the patient and documented "no evidence of imminent harm to self or others" and "is currently a LOW short term risk" (for completing suicide) with "no clear imminent risk of suicide," but did not sign the note for approximately 25 hours.[9]

On day 3, a nurse (Nurse 3) documented that the patient denied suicidal thoughts and wanted to speak with the psychiatrist about removing the 1:1. MOD 2 completed an evaluation the same morning and noted the patient was still receiving medications for active alcohol withdrawal symptoms and, despite denying suicidal ideations, remained on 1:1.

That afternoon, at 5:32 p.m., the psychiatrist discontinued the 1:1 order and placed the patient on checks every 15 minutes. In a progress note signed at 5:41 p.m., the psychiatrist wrote "Patient not seen today." Nursing staff documented checking on the patient every 15 minutes throughout the night. On day 4 at 12:54 a.m., a nurse (Nurse 4) documented the patient scored a 13 on the CIWA-Ar assessment. The CIWA-Ar scores on day 3 were 9 at 3:43 p.m., 3 at 5:28 p.m., and 5 at 9:36 p.m.

At 2:30 a.m. on day 4, the CNA documented observing the patient "laying in bed." The MOD (MOD 3) documented the patient was found at 2:45 a.m. in the bathroom hanging from the necklace attached to a ceiling lift.[10] Medical unit staff performed cardiopulmonary resuscitation.[11] MOD 3 pronounced the patient dead at 3:21 a.m.

Three days after the patient's death (day 7), the facility's Chief of Staff (COS) and risk manager met with the patient's family members and completed an institutional disclosure.

[8] The psychiatrist reported not being located at the facility and provided mental health care to patients through video conferencing (telehealth).

[9] An unsigned note cannot be viewed by other clinical providers.

[10] VHA Healthcare Environment and Facilities Programs (HEFP) Enterprise Support Service, "Safe Patient Handling and Mobility Guidebook," http://vaww.hefp.va.gov/sites/default/files/files/2023-05/SPHM%202022.pdf. (This website is not publicly accessible.) A ceiling lift is a full body lifting device used to move patients out of beds, into and out of chairs, or for repositioning. The lift is mounted to the ceiling on an overhead track for accessibility and ease of use.

[11] Mayo Clinic, "Cardiopulmonary resuscitation (CPR): First Aid," accessed November 2, 2023, https://www.mayoclinic.org/first-aid/first-aid-cpr/basics/art-20056600. A life-saving technique useful in emergencies in which breathing or heartbeat has stopped that helps keep oxygenated blood moving through the body until a heart rhythm is restored.

Inspection Results

Inadequate Clinical Care of the Patient Prior to Suicide

The OIG assessed the clinical care provided by facility staff to manage the patient's suicidal ideations and alcohol withdrawal.

Deficiencies in the Management of Suicidal Ideation

The OIG substantiated that the patient received inadequate care for suicidal ideation. Specifically, the psychiatrist failed to reassess the patient prior to discontinuing the 1:1 and sign documentation timely; facility staff failed to provide a warm handoff after a positive C-SSRS, complete a Comprehensive Suicide Risk Evaluation (CSRE), and remove belongings and environmental risks.

Failure to Reassess the Patient Before Changing the Observation Status

VHA recommends suicidal patients be placed on 1:1 when being treated on a medical unit.[12] Facility SOPs state that while patients are on 1:1, the psychiatrist on call will evaluate the patient daily; when the patient has improved sufficiently, the psychiatrist will write an order to discontinue 1:1 and will identify the observation procedures to follow.[13] The associate chief of staff for mental health and the psychiatrist's supervisor told the OIG that transitioning a patient from 1:1 to checks every 15 minutes should be based upon a same day clinical evaluation by a psychiatrist.

According to the EHR, MOD 1 admitted the patient to the medical unit and placed an order for 1:1 due to suicidal ideation. The next day (day 2), in response to a consultation request by MOD 1, the psychiatrist completed a telemental health evaluation of the patient.[14] The psychiatrist documented that the patient was at low risk for suicide and told the OIG that the 1:1 was maintained due to concerns for alcohol withdrawal and seizures.

On day 3, the psychiatrist entered an order to change the 1:1 to checks every 15 minutes without re-evaluating the patient. The psychiatrist explained the decision to change the patient's observation status was due to the belief that the patient was not suicidal and told the OIG of an intent to see the patient the next day. Although there was a plan to see the patient the next day,

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

[13] Facility SOP 116-11, "Psychiatrist On-Call," March 2, 2021; Facility SOP 116-05, "Identification and Management of Suicidal Behavior," November 18, 2020.

[14] The supervisory psychiatrist told the OIG that patients in the facility's medical unit who are in need of mental health services receive care from psychiatry staff either in-person or through telehealth modalities.

the psychiatrist should not have relied on the previous evaluation and was required to reassess the patient for any changes in symptoms or behavior.

Delayed Documentation and Lack of Communication

According to facility bylaws, inpatient notes should include important medical impressions and be authenticated by the provider as soon as possible, but always within 24 hours of being written.[15] In addition, "inadequate information exchange can have tragic consequences on patient safety"; the Joint Commission recognizes communication errors as "the most common attributable root cause" of sentinel events.[16]

On day 2, the psychiatrist started a psychiatric consult note identifying the patient as "LOW short term risk" for suicide, but did not sign the consult note within the required 24-hour time frame. The psychiatrist told the OIG that the telemental health note was not signed within 24 hours due to need for chart review, dictation, and note edits. MOD 2 told the OIG that on the next day (day 3), a nursing staff member requested the removal of the 1:1. However, MOD 2 reported being uncomfortable removing the 1:1 unless the patient was on the acute psychiatric unit. MOD 2 told the OIG that the psychiatrist signed the consult note and changed the patient's observation status from 1:1 to checks every 15 minutes after MOD 2's shift ended.

MOD 2 stated that had the consult note been available, a conversation with the psychiatrist would have occurred to convey the opinion that checks every 15 minutes were not adequate for this patient in the medical unit and to suggest moving the patient to an acute psychiatric unit. The psychiatrist told the OIG that knowledge of the MOD's opinion "would have definitely helped."

Failures in the Suicide Risk Evaluation Process

Facility policy requires clinical staff to complete the C-SSRS, a suicide screen, for patients admitted to a facility's medical unit.[17] Staff who identify a positive C-SSRS must initiate a warm handoff to a licensed independent practitioner (LIP) for completion of the CSRE within 24 hours.[18] The CSRE is an assessment tool that includes factors that indicate a patient's suicide risk

[15] Facility Policy, "Bylaws and Rules of the Medical Staff of Veterans Health Administration (VHA)," September 15, 2022. Authentication is used to validate a health record entry and requires association with a signature, written or electronic; VHA Program Guide, *HIM Health Record Documentation Program Guide*, Version 1.2, September 29, 2023.

[16] Oren T. Guttman, Elizabeth H. Lazzara, Joseph R. Keebler, Kristen L. W. Webster, Logan M. Gisick, and Anthony L. Baker, "Dissecting Communication Barriers in Healthcare: A Path to Enhancing Communication Resiliency, Reliability, and Patient Safety," *Journal of Patient Safety* Vol. 17, No. 8 (December 2021): e1465-e1471, https://journals.lww.com/journalpatientsafety/fulltext/2021/12000/dissecting_communication_barriers_in_healthcare__a.110.aspx; The Joint Commission defines a sentinel event as "a patient safety event that results in death, permanent harm, or severe temporary harm." The Joint Commission, "Sentinel Event," accessed March 27, 2024, https://www.jointcommission.org/resources/sentinel-event/.

[17] Facility SOP 116-05.

[18] Facility SOP 116-05.

level and assists LIPs in developing a plan that mitigates a patient's risk for suicide.[19] Additionally, MOD 1 told the OIG that the expected process prior to the suicide was for a psychiatry provider to complete the CSRE.

According to the EHR, on the day of admission (day 1), Nurse 1 completed a C-SSRS with a positive result at 8:05 p.m. and documented "MOD already aware and Veteran is already on expected precautions." In an interview with the OIG, Nurse 1 reported not having an awareness of the expectation to notify an LIP of a positive C-SSRS via a warm handoff. MOD 1 reported to the OIG an awareness that the patient was suicidal, entry of a psychiatry consultation, and an expectation that the psychiatrist would complete the CSRE. MOD 1 also reported not speaking with the psychiatrist. The psychiatrist reported not having awareness that the C-SSRS was positive and that a CSRE was required. Although not documented, the psychiatrist stated all elements of the CSRE were considered during the telemental health evaluation on day 2, and remained confident in the determination that the patient was low risk for suicide. In interviews with the OIG, the psychiatrist's supervisor reported reviewing the patient's EHR and concurred with the psychiatrist's assessment that the patient was at low risk for suicide.

Failure to Remove Belongings and Environmental Risks

Strong evidence indicates that suicidal events can be decreased if objects that can be used to inflict self-induced harm are removed.[20] Facility SOPs require unit staff to inventory belongings and perform a hazardous items check for all patients admitted to the medical unit.[21] For patients with 1:1 orders, staff are required to remove and secure a patient's belongings.[22] Additionally, the facility SOP states that when patients are admitted with suicidal ideation, staff should "eliminate environmental risk factors to the greatest degree possible" by removing equipment such as nurse call light cords, sheets, oxygen tubing, and plastic bags from the patient's room.[23]

The OIG found that upon admission, the CNA documented an inventory of belongings and noted that the patient maintained possession of items that included a bracelet and necklace, contrary to

[19] RISK ID, Suicide Risk Identification, VA Comprehensive Suicide Risk Evaluation (CSRE) Printable Worksheet, Appendix B, accessed August 8, 2023, https://www.mirecc.va.gov/visn19/cpg/recs/3/. Patients at high acute risk typically require psychiatric hospitalization and "need to be directly observed until on a secure unit and kept in an environment with limited access to lethal means." Patients at intermediate acute risk need consideration for psychiatric hospitalization and need frequent contact with regular reassessment of risk. Patients at low acute risk can be managed in primary care settings.

[20] Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., Carli, V., Höschl, C., Barzilay, R., Balazs, J., Purebl, G., Kahn, J. P., S?iz, P. A., Lipsicas, C. B., Bobes, J., Cozman, D., Hegerl, U., Zohar, J. "Suicide prevention strategies revisited: 10-year systematic review," *Lancet Psychiatry*, (2016), 3(7), 646–659, https://pubmed.ncbi.nlm.nih.gov/27289303/; VA, "Lethal Means Safety & Suicide Prevention," accessed January 18, 2024, https://www.mirecc.va.gov/visn19/lethalmeanssafety/.

[21] Facility SOP 135-06, "Patient Clothing, Valuables and Effects," February 22, 2023; Facility SOP 118-38.

[22] Facility SOP 118-38.

[23] Facility SOP 116-05.

facility policy.[24] The CNA reported to the OIG that a decision was made with Nurse 1 to permit the patient to maintain possession of all belongings (minus a cellphone charger); the necklace and bracelet were allowed due to sentimental value expressed by the patient. Of note, the patient's necklace was described as a "paracord" (parachute cord) necklace that can hold up to 550 pounds. Despite clear guidance in facility policy, Nurse 1 reported being less concerned about removing belongings because the patient was on 1:1.[25] The Associate Director of Patient Care Services, COS, Facility Director, chief of nursing service, patient safety manager, and quality safety value chief told the OIG that "drift" from facility policies had occurred among staff, resulting in decisions being made that were inconsistent with policy, such as allowing the patient to maintain possession of the belongings. These decisions, ultimately, put the patient at risk.

While on 1:1, according to facility policy, the patient should not have been allowed to maintain possession of the personal items, including the necklace.[26] However, following interviews with nurse 4 and the CNA, the OIG recognizes the patient would have been allowed to receive the personal items back once the observation status was changed to checks every 15 minutes.

There was also a failure to remove environmental risks from the patient's room in a manner consistent with facility policy.[27] The CNA stated that because the patient was on 1:1, nothing was removed from the room. Nurse 1 documented that an environmental risk check was completed; however, in an interview with the OIG stated, "I failed to verify everything." Although staff may not be able to make rooms on the medical unit completely free of hazardous items given that the rooms are designed for medical care and not psychiatric care, staff should have mitigated the environmental risks to the greatest degree possible, even though 1:1 was ordered.

In summary, the OIG concluded that clinical staff did not provide adequate care to manage the patient's suicidal ideations. Specifically, clinical staff did not adhere to policies or SOPs in the following instances:

- The psychiatrist reported not reassessing the patient as required when making the decision to remove the 1:1.
- The psychiatrist and MOD 2 had different opinions about the removal of the patient's 1:1 and were not aware of each other's clinical impressions due to the psychiatrist's consult note not being signed timely and a lack of interdisciplinary communication.
- Nurse 1 did not provide a warm handoff of the positive C-SSRS to an LIP.

[24] Facility SOP 118-38.
[25] Facility SOP 118-38.
[26] Facility SOP 116-05.
[27] Facility SOP 116-05.

- An LIP did not complete the required CSRE, and the psychiatrist's consult note did not contain all of the elements that would be found in a CSRE.
- Staff did not remove and secure the patient's belongings and eliminate environmental risk factors to the greatest degree possible.

Management of Alcohol Withdrawal

The OIG did not substantiate that clinical staff provided inadequate care for the patient's alcohol withdrawal. The OIG found that nursing staff made one medication error but otherwise followed the CIWA-Ar protocol and dosing, as ordered, to monitor and treat the patient.

VHA recommends clinical staff use standardized measures such as the CIWA-Ar protocol to assess, monitor, and manage alcohol withdrawal symptoms.[28] VHA recommends using benzodiazepines (such as lorazepam) for the treatment of moderate to severe alcohol withdrawal.[29] The orders entered in the EHR for clinical staff to manage the patient's alcohol withdrawal are located in table 1.

Table 1. CIWA-Ar Protocol Orders

CIWA-Ar Score	Lorazepam Dosing
0–7: assess Q4H while awake and PRN	none
8–12: assess Q2H while awake and PRN	1 mg
13–17: assess Q2H while awake and PRN	2 mg
18–23: assess Q1H while awake and PRN	3 mg
24 plus: assess Q1H while awake and notify MD	4 mg (notify MD)

Source: Orders from MOD 1 in the patient's EHR.
Note: For the purpose of this table, PRN is "as needed" and QH is "every hour." For example, Q1H is every one hour.

Upon the patient's admission to the facility, MOD 1 placed orders for nursing staff to assess and treat the patient with lorazepam based on the CIWA-Ar protocol. Nursing staff documented the CIWA-Ar assessments as ordered every 1–4 hours.[30] The OIG analyzed the timing of completed CIWA-Ar assessments, and the lorazepam dose given based on the scores and found that nursing staff followed the orders except for one error. Two days prior to the patient's suicide, Nurse 1 administered 2 milligrams instead of 1 milligram of lorazepam for a CIWA-Ar score of 12. The

[28] VA and Department of Defense, *VA/DOD Clinical Practice Guideline for the Management of Substance Use Disorders 4.0*, August 2021 (VA-DoD CPG).

[29] VA/DoD CPG; Cleveland Clinic, "Benzodiazepines (Benzos)," accessed March 28, 2024, https://my.clevelandclinic.org/health/treatments/24570-benzodiazepines-benzos. "Benzodiazepines are a class of medications that slow down activity in your brain and nervous system."

[30] There were three episodes of "no score" documented because the patient was asleep (documented on June 3, 2023, at 12:39 a.m., 4:28 a.m., and 10:51 p.m.)

OIG determined that the additional 1 milligram of medication administered two days prior to the completed suicide had no impact on the patient's outcome.[31] The medical unit nurse manager reported addressing the error with Nurse 1.

The OIG concluded that nursing staff appropriately managed the patient's alcohol withdrawal symptoms using the CIWA-Ar protocol and lorazepam orders, except for the one medication error discussed above. The OIG determined that there was no correlation between the medication error and the patient's suicide.

Facility Leaders' Response to the Patient Suicide

The OIG determined that facility leaders evaluated and addressed the patient's suicide through the use of a variety of follow-up actions, including a root cause analysis (RCA), in accordance with VHA policy.[32]

VHA policy states that an RCA is a "comprehensive team-based, systems-level investigation with a formal charter for review of health care adverse events and close calls."[33] The VHA National Center for Patient Safety stated, "The goal of each RCA is to find out what happened, why it happened, and what must be done to prevent it from happening again."[34]

The Facility Director chartered an RCA on the same day of the patient's suicide and later concurred with the corresponding action plans and outcome measures. The OIG determined that the action plans addressed the concerns identified in this report.

Conclusion

The OIG concluded that clinical staff did not provide adequate care by not adhering to policies or SOPs when providing care to manage the patient's suicidal ideations. Specifically, the psychiatrist did not reassess the patient as required when making the decision to remove the 1:1. The psychiatrist and MOD 2 had different opinions about the removal of the patient's 1:1 and were not aware of each other's clinical impressions due to the psychiatrist's consult note not being signed timely and a lack of interdisciplinary communication. After the patient was

[31] The OIG also determined that the medication error had no adverse impact to the patient.

[32] VHA Directive 1050.01, *VHA Quality and Patient Safety Programs*, March 24, 2023. The OIG reviewed the patient's EHR and facility documents and found that facility leaders ensured the completion of an institutional disclosure and peer review, in addition to the RCA.

[33] VHA Directive 1050.01. "For the purpose of this directive, adverse events are untoward diagnostic or therapeutic incidents, iatrogenic injuries, or other occurrences of harm directly associated with care or services delivered by VA providers." "For the purpose of this directive, a close call is an event or situation that could have resulted in an adverse event but did not, either by chance or through timely intervention." The RCA charter memorandum identified the patient's suicide as an adverse event.

[34] "About the National Center for Patient Safety," VHA National Center for Patient Safety, accessed March 20, 2024, https://www.patientsafety.va.gov/about/index.asp.

admitted, Nurse 1 did not provide a warm handoff of the positive C-SSRS to an LIP. Additionally, an LIP did not complete the required CSRE. Staff also did not remove and secure the patient's belongings and eliminate environmental risk factors to the greatest degree possible.

Nursing staff appropriately managed the patient's alcohol withdrawal symptoms using the CIWA-Ar protocol and lorazepam orders, except for one medication error. The OIG determined that there was no correlation between the medication error and the patient's suicide.

The Facility Director chartered an RCA on the same day of the patient's suicide and later concurred with the corresponding action plans and outcome measures. The OIG determined that the action plans addressed the concerns identified in this report.

The OIG concluded that the deviations from policies or SOPs outlined in this report ultimately placed the patient at greater risk for suicide.

Recommendations 1–4

1. The Sheridan VA Medical Center Director ensures completion of warm handoffs and Comprehensive Suicide Risk Evaluations within 24 hours for patients on the medical unit that screen positive on the Columbia-Suicide Severity Rating Scale.
2. The Sheridan VA Medical Center Director ensures that psychiatry or medical officer of the day staff reassess suicidal patients prior to changing a one-to-one observation status order.
3. The Sheridan VA Medical Center Director ensures that inpatient notes are completed and authenticated by providers as soon as possible, but always within 24 hours, in accordance with facility policy.
4. The Sheridan VA Medical Center Director ensures that staff follow facility policies for removing belongings and environmental risks for suicidal patients on one-to-one observation status on the medical unit.

Appendix A: VISN Director Memorandum

Department of Veterans Affairs Memorandum

Date: May 16, 2024

From: Director, VA Rocky Mountain Network (10N19)

Subj: Healthcare Inspection—Inadequate Care of a Patient Who Died by Suicide on a Medical Unit at the Sheridan VA Medical Center in Wyoming

To: Director, Office of Healthcare Inspections (54HL10)
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

1. We are incredibly saddened by the loss of this Veteran and our thoughts are with the Veteran's family. VISN 19 is committed to performing at the highest standards and finding ways to improve our response to Veterans in crisis. Any Veteran suicide is one too many and VISN 19 remains committed to our mission to support those in suicide crisis. We are utilizing this review to strengthen processes for improved suicide prevention and zero harm.

2. We deeply regret the circumstances that led to this Veterans death. There is nothing more important to us in VISN 19 than ensuring Veterans receive quality care and that it is provided by knowledgeable, skilled staff. We appreciate the opportunity to review and comment on the Office of Inspector General (OIG) report, Inadequate Care of a Patient Who Died by Suicide on a Medical Unit at the Sheridan VA Medical Center in Wyoming.

3. Based on a thorough review of the report by VISN 19 Leadership, I concur with the recommendations and submitted action plans of Sheridan VA Health Care System. These recommendations will be used to strengthen our processes and improve the care that is provided to our Veterans.

4. I would like to thank the Office of Inspector General for their thorough review and if there are any questions regarding responses or additional information required, please contact the VISN 19 Quality Management Officer.

(*Original signed by*:)

Sunaina Kumar-Giebel, MHA
Director, Rocky Mountain Network (10N19)

[**OIG comment:** The OIG received the above memorandum from VHA on June 27, 2024.]

Appendix B: Facility Director Memorandum

Department of Veterans Affairs Memorandum

Date: June 6, 2024

From: Director, Sheridan VA Medical Center (666/00)

Subj: Healthcare Inspection—Inadequate Care of a Patient Who Died by Suicide on a Medical Unit at the Sheridan VA Medical Center in Wyoming

To: Director, VA Rocky Mountain Network (10N19)

1. We appreciate the opportunity to work with the Office of the Inspector General as we continuously strive to improve the quality of healthcare for America's Veterans. Our heartfelt condolences go out to the Veteran's family and all who knew them. We are deeply committed to doing everything within our ability to strengthen and improve our processes involved with suicide prevention.

2. A tragic event of this nature is never acceptable. Despite striving to provide high-quality, Veteran-centered care, the care provided to this Veteran was flawed. We at Sheridan VA Medical Center have reflected upon this tragedy and have implemented changes to ensure to the best of our ability that an event of this nature does not happen again.

3. We thank the Office of Inspector General for their thorough review which assisted us in improving the care we provide to Veterans. If you have any questions, please contact the Sheridan Chief of Quality and Patient Safety.

(*Original signed by*:)

Pamela S. Crowell, MPA
SVAHCS Director

[**OIG comment:** The OIG received the above memorandum from VHA on June 27, 2024.]

Facility Director Response

Recommendation 1

The Sheridan VA Medical Center Director ensures completion of warm handoffs and Comprehensive Suicide Risk Evaluations within 24 hours for patients on the medical unit that screen positive on the Columbia Suicide Severity Rating Scale.

_X _Concur

____Nonconcur

Target date for completion: December 31, 2024

Director Comments

On September 12, 2023, the Medical Unit Nurse Manager re-educated Medical Unit RNs about SOP 116-05 (Identification and Management of Suicidal Behavior) and targeted the need for warm handoff when a positive Columbia-Suicide Severity Rating Scale (C-SSRS) occurs. The Assistant Chief of Mental Health provided training to the Medical Officers of the Day (MOD) using a combination of live instruction and simulation on completion of the Comprehensive Suicide Risk Evaluation (CSRE) on October 31, 2023. A monitoring plan has been established to review the compliance with the warm hand off and CSRE completion and will be reported at the monthly Quality Patient Safety Board and captured in the minutes. When warranted, action will be taken to address any trends indicating the need to intervene.

Recommendation 2

The Sheridan VA Medical Center Director ensures that psychiatry or medical officer of the day staff reassess suicidal patients prior to changing a one-to-one observation status order.

_X _Concur

____Nonconcur

Target date for completion: December 31, 2024

Director Comments

A workgroup was developed August 28, 2023, to create a checklist to be utilized by the Medical Officer of the Day (MOD), the Psychiatrist on Call (POC), and the RN. The checklist is intended to support establishing interdisciplinary team communication guidelines between all parties prior to the MOD or POC discontinuing 1:1 patient observation for suicidal ideation for Veterans on the Medical Unit. Education was provided on the implementation of the checklist to the MODs on November 30, 2023, the POCs on December 6, 2023, and the Medical Unit RNs on December 20, 2023. This checklist was reviewed in Clinical Practice Committee (CPC) on 4/8/2024 and

approved. It will be added as an Attachment G to SOP 116-05: Identification and Management of Suicidal Behavior. This will be completed by 6/30/24.

Recommendation 3

The Sheridan VA Medical Center Director ensures that inpatient notes are completed and authenticated by providers as soon as possible, but always within 24 hours, in accordance with facility policy.

_X _Concur

____Nonconcur

Target date for completion: December 31, 2024

Director Comments

Reinforcement of education to all Medical Officers of the Day (MODs) and Psychiatrists on Call (POC) regarding timeliness of completing and authenticating inpatient notes as soon as possible, but always within 24 hours, in accordance with facility policy, will be completed by Associate Chiefs of Staff (ACOS) for Medicine and Mental Health or a designee. This was completed by the MOD Supervisor (ACOS Medicine designee) for MODs on May 29, 2024. Education for POCs is scheduled to be completed on June 30, 2024. This education is provided to all MODs and POCs as part of their orientation as well.

Recommendation 4

The Sheridan VA Medical Center Director ensures that staff follow facility policies for removing belongings and environmental risks for suicidal patients on one-to-one observation status on the medical unit.

_X _Concur

____Nonconcur

Target date for completion: January 31, 2025

Director Comments

SOP 118-38: Hazardous Items Checks Attachment B Medical Unit was updated June 8, 2023. Education on SOP 118-38 and Attachment B was completed on October 16, 2023. On August 23, 2023, education on SOP 116-05 (Identification and Management of Suicidal Behavior) Attachment D: Suicide Precaution Environmental Checklist was provided to Medical Unit Nursing staff to reinforce correct use of the checklist. Medical Unit patient care staff (i.e. RNs, LPNS, NAs) will take part in an additional simulation activity of clearing a room by using the checklist to ensure understanding of how to use this tool. Completion of this additional

simulation will be reported in the Quality Patient Safety Board meeting and captured in minutes of evidence of completion.

OIG Contact and Staff Acknowledgments

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