



Department of Veterans Affairs Office of Inspector General

Healthcare Inspection

Suicide After Hospitalization At a Veterans Health Facility

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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 veteran who committed suicide after discharge from a Veterans Healthcare facility. The patient was hospitalized for treatment of depression and anxiety. Throughout his hospitalization, he denied any suicidal ideations. Clinicians made reasonable decisions and made acceptable discharge plans based on what they knew about the patient's home safety situation. At the time of discharge, the patient was competent to make decisions and did not voice suicide ideations.

We found that the patient received appropriate care. We made no recommendations.



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

TO: Director, Veteran Integrated Service Network

SUBJECT: Healthcare Inspection – Suicide After Hospitalization at a Veterans Health Care Facility

Purpose

The VA Office of Inspector General (OIG), Office of Healthcare Inspections, conducted an evaluation to review the care of a patient who committed suicide after treatment and discharge from a Veterans Health Care facility (the medical center).

Background

The medical center provides medical, surgical, and mental health services. It operates 72 beds and provides services at five community based outpatient clinics (CBOCs). The medical center is affiliated with a University for Medical Sciences and supports a limited family practice residency program.

Scope and Methodology

We interviewed the patient's sister and nephew. We obtained and reviewed the autopsy report and related toxicology test results. We reviewed policies, directives, VHA suicide risk assessment references, the American Psychiatric Association (APA) guideline on suicide assessment and prevention, the patient's medical records, and the suicide safety plans of 33 medical center patients assessed to be at high risk for suicide.

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

Case Summary

The patient was a veteran who was service-connected for post-traumatic stress disorder (PTSD). His medical history included hyperlipidemia, chronic low back pain (LBP)

related to a degenerative spinal condition, hearing loss, and major depressive disorder (MDD).

From 2001 to October 2009, the patient was routinely seen and treated in the clinic setting for depression, anxiety, LBP, and PTSD. At the request of the patient, providers often changed and adjusted his medications. Further, the medical record periodically reflects that providers counseled the patient about taking his medications as prescribed and advised him not to take pain medications given to him by a friend. Progress note entries by the patient's primary care and mental health providers consistently reflect that the patient was assessed for suicidality and that he routinely denied suicidal ideation (SI).

The patient was seen four times in 2009 by either his primary care provider (PCP) or MH provider at a CBOC. Providers documented the patient's ongoing depression without SI, and noted making multiple medication adjustments and changes. During this time, the patient also received medications from a non-VA provider

During an August 2009 MH appointment, the patient noted that his live-in girlfriend was moving out. He stated he had stopped taking one of his medications and didn't think another was effective. He told the provider he was thinking about moving closer to his sisters, and again denied any SI.

In early November, a family member contacted a social worker at the medical center and expressed concern for the patient's well-being. On that same day, the social worker attempted to contact the patient by telephone and followed up with a registered letter to him. The patient called the telephone triage line 11 days later and told the nurse he was depressed and had not been doing well. He also stated he had occasional thoughts of suicide but denied any plan or intent. He agreed to be seen in MH, and the nurse scheduled an appointment for 2 days later.

The MH provider completed a suicide risk assessment during the clinic visit, and concluded that the patient was at chronic moderate risk, but not at imminent risk, for suicide. The provider noted the patient was unclear regarding what medications he was supposed to be taking, was depressed, but was motivated and willing to be hospitalized. Admission to an inpatient unit was arranged for the following day. The patient agreed to relinquish his guns to his family members and was given emergency phone numbers prior to leaving the clinic.

The next day, the patient was admitted to an inpatient MH unit at the medical center for depression and anxiety and placed on 15-minute checks for safety. At the time of admission, he denied any thoughts of suicide. His global assessment of functioning

(GAF) score was 35.¹ He told the admitting provider that he thought there was something wrong with his medications.

Over the next 4 days, the patient participated in group treatment sessions, interacted well with others, and gained privileges to leave the unit. Providers continued to adjust his medications. The patient reported that he was doing better and his medications seemed to be working. His suicide risk assessment reflected he was at chronic low risk, but not at imminent risk, for suicide.

On hospital day (HD) 5, the patient asked to meet with the provider to formulate a discharge plan. He stated he felt the medications were helping but he felt confined even though he could leave the unit. He agreed he needed to stay until he felt better.

On HD 6, the patient met with the treatment team and requested discharge for the following day. He denied any SI and agreed with a follow-up plan. Progress notes show that the interdisciplinary treatment goals to decrease depression by 25-percent and eliminate SI were both met. A suicide risk assessment indicated the patient to be chronic minimal risk, but not at imminent risk. His GAF score was 50, which indicated improvement in his level of functioning at the time. The treatment team agreed to discharge the patient the following day.

On HD 7, the patient received discharge instructions which included emergency suicide hotline and medical center crisis line telephone numbers. The pharmacist documented that the patient left before discussing his medications, so the nursing staff provided education on the discharge medications, which included a medications for depression and to promote sleep, and a vitamin.

A shuttle bus took the patient back to the CBOC where he had left his car. Later the same day, the patient's sister called the telecare MH nurse to tell them that the patient was very upset and making suicidal statements after finding out his home had been burglarized while he was hospitalized. She told the nurse they had removed his guns. She also stated that he did not come home with his medications. The sister was counseled to take the patient to the nearest ER if he was a danger to himself. The sister verbalized understanding.

We could not determine if the patient left before receiving his medications or if he left them on the shuttle bus. The patient's medications arrived 2 days later, by courier. The telecare MH nurse contacted the patient and reviewed the medications with him. He told her that he was still depressed and had occasional thoughts of suicide; however, he denied any plan or intent. He agreed that if at any time he felt unsafe, he would have his sister take him to the nearest ER. He agreed to keep his upcoming MH appointment

¹ The GAF is a numeric scale (0 through 100) used by MH clinicians to subjectively rate the social, occupational, and psychological functioning of adults.

scheduled for the following week. The nurse documented that she gave him a toll-free number to access emergency care if needed.

Two days later, the sister notified the medical center staff that earlier in the morning, her brother had committed suicide with his gun. The autopsy report ruled the manner of death as suicide by gunshot.

Inspection Results

We found that the patient received appropriate treatment and services, both as an outpatient and during his hospitalization. The patient had a long history of depression and SI without plan or intent. Suicide risk assessments were routinely completed and documented, and outpatient treatment consisted of regular MH and primary care appointments over a number of years. The APA treatment guidelines² recommend pharmacological and psychosocial interventions for patients with SI and behaviors. Providers regularly adjusted medications to address the patient's perceptions that some of his medications were, or had become, ineffective.

Inpatient treatment included addressing the risk factors of depression and medication non-compliance. Clinicians ordered anti-depressants and medications for anxiety and sleep, and the patient participated in group therapy sessions. Interventions to assure his physical safety included frequent monitoring initially, with a gradual increase in privileges as he responded to treatment.

Prior to discharge, the patient told the clinicians that he was feeling and sleeping better. The staff documented that he was calm and pleasant and interacted with the other veterans on the unit. At the treatment team meeting the day before discharge, the patient denied any suicidality and requested discharge. He also agreed to follow-up with the MH clinician at the CBOC and that if he experienced SI, he would return to the medical center "instead of acting out."

After the patient's discharge, two incidents occurred that possibly influenced the subsequent events. First, the family told us that the patient's television was stolen while he was hospitalized; however, he did not learn of this event until after he returned home. The family told us that upon learning about his stolen television, the patient became very upset, was yelling, and was hitting the wall. They offered to take him to a community MH treatment center, but he refused. Had the medical center staff been aware of the incident, they could have assisted the patient in dealing with this unanticipated and stressful event while he was still hospitalized in a therapeutic environment.

² The APA *Practice Guideline for the Assessment and Treatment of Patients with Suicidal Behaviors*, Psychiatric Annals 34:5, May 2004.

Second, the patient's sister returned his gun to him because he threatened violence if he did not get the weapon back. He told his family that he felt unsafe due to the break-in and that if he wanted to hurt himself, he could use means other than a gun.

The family stated that they saw him on Thursday, Friday, and Saturday after discharge, and he did not seem upset. When leaving on Saturday, he told his family that he would see them on Sunday to participate in a family birthday celebration. Based on his mood and behavior, they did not suspect that he was at imminent risk for suicide.

Conclusions

We found that the patient received appropriate care. Clinicians made reasonable decisions and constructed an acceptable discharge plan based on what they knew about the patient's home safety situation. At the time of discharge, the patient was competent to make decisions and did not voice SI. There were no apparent clinical indications for continued hospitalization. We made no recommendations.

(original signed by:)

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

OIG Contact and Staff Acknowledgments

OIG Contact	Susan Zarter, Associate Director Atlanta Office of Healthcare Inspections (404) 929-5966
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Acknowledgments	Victoria Coates Tishanna McCutchen Michael Shepherd, MD
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