



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 15-03713-288

Healthcare Inspection

**Emergency Department,
Mental Health Service, and Suicide
Prevention Training Concerns
Mann-Grandstaff VA Medical Center
Spokane, Washington**

September 14, 2016

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection at the request of Senator Patty Murray in response to allegations of failures in Emergency Department (ED) care, mental health services, and suicide prevention training at the Mann-Grandstaff VA Medical Center (facility), Spokane, WA. The specific requests were:

- Evaluate the steps the facility has taken to recruit and retain ED providers.
- Assess the risk for deficiencies in care as a result of operating hour restrictions on the facility's ED.
- Review a complaint of substandard care that may have contributed to the death by suicide of a patient.
- Evaluate the facility's compliance with suicide prevention training requirements.

We did not substantiate a failure to actively recruit and retain qualified ED providers. We did not substantiate that the facility's change from an ED to an Urgent Care Clinic (UCC) with a reduction in operating hours resulted in a deficiency in care. We determined that the facility was thoughtful in planning an approach to align the delivery of care with resources thereby reducing the potential for adverse events after the loss of ED providers. Facility leaders took steps to inform the public before changing to a UCC and tracked after-hour attempts to access care once the change occurred. As of May 2016, the facility continues to operate as a UCC, the average number of patients has remained constant, and the facility is able to efficiently care for the patients.

We did not substantiate that quality of care issues contributed to the death by suicide of a patient. We determined that from the time of his initial contact until his last contact with the facility's mental health staff, the patient was assessed by an interdisciplinary team for risk of suicide on multiple occasions and determined to be not at risk for self-harm. Mental health services provided were consistent with relevant Veterans Health Administration (VHA) directives.

We substantiated that facility leaders failed to comply with VHA requirements for suicide prevention training. We found that health care providers, as defined by VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training*, June 27, 2014, had not completed the Suicide Risk Assessment for Clinicians course within the required first 90 days of hire. We determined the facility lacked a process to assign and track the required training.

We recommended that the Interim Facility Director strengthen processes to ensure suicide prevention training is completed per VHA requirements and monitor compliance. Updated data provided by the facility showed that only three staff were delinquent in completion of the training as of May 17, 2016.

Comments

The Veterans Integrated Service Network and Interim Facility Directors concurred with our recommendation and provided an acceptable action plan. (See Appendixes A and B, pages 12–14 for the Directors' comments.) The facility has provided evidence of follow-up on the planned action resulting in closure of the recommendation at the time of publication.



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

Purpose

The VA Office of Inspector General (OIG) Office of Healthcare Inspections conducted an inspection at the request of Senator Patty Murray in response to allegations of failures in Emergency Department (ED) care, mental health (MH) services, and suicide prevention training at the Mann-Grandstaff VA Medical Center (facility), Spokane, WA. The purpose of the inspection was to determine if the allegations had merit.

Background

Facility Profile. The facility is located in Spokane, WA, and is part of Veterans Integrated Service Network (VISN) 20. VISN 20 comprises eight parent facilities and includes the states of Washington, Oregon, Alaska, Idaho, and one county each in California and Montana. VISN 20 covers nearly 23 percent of the United States land mass.

The Veterans Health Administration (VHA) categorizes facilities according to complexity level. The level is determined based on the characteristics of the patient population, clinical services offered, educational and research missions, and administrative complexity. Facilities are classified into three levels. The most complex facilities are Level 1, and the least complex are classified as Level 3. A Level 1 complexity designation indicates a facility has the infrastructure and staff needed to treat high-risk patients with complex medical and surgical needs.

The facility is designated as Level 3 and provides primary and secondary care, with emphasis on preventive health and chronic disease management. In fiscal year 2015 (October through April) the facility served 26,053 unique patients and operated 36 hospital beds and 34 rehabilitation-oriented nursing home beds. Community Based Outpatient Clinics are located in Wenatchee, WA, and Coeur d'Alene, ID.¹

OIG reviewed the facility's ED in 2012 after receiving allegations that patients who initially presented to the ED were referred to primary care where they were screened by primary care nursing staff, with only a fraction of the patients being seen by a licensed provider. The complainant added that many patients were sent home without same-day care, having to return again. The report *Healthcare Inspection—Quality of Care Issues, Spokane VA Medical Center, Spokane, WA, April 21, 2015, Report No. 12-02884-218* concluded that the facility had resolved the issue prior to the OIG review, and patients were no longer referred by the ED to primary care.² Effective December 1, 2014 the facility changed the status of the ED to an Urgent Care Clinic while in the process of recruiting ED physicians.

¹ *Combined Assessment Program of the Mann-Grandstaff VA Medical Center, Spokane, WA, July 28, 2015, Report No. 15-00599-438.*

² *Healthcare Inspection—Quality of Care Issues, Spokane VA Medical Center, Spokane, WA, April 21, 2015, Report No. 12-02884-218.*

Emergency and Urgent Care Services. VHA Directive 2010-10 states, “the primary responsibility of the ED is to provide resuscitative therapy and stabilization in life-threatening situations” and should be equipped and staffed to operate 24 hours a day, 7 days a week, providing emergency care in a clearly defined area.³ EDs must have adequate staff and resources available to evaluate all individuals presenting for emergency care and must be staffed by experienced and qualified physicians and nursing, laboratory, and radiology personnel.⁴

VHA policy defines Urgent Care Clinics (UCCs) as “clinics designed to provide care to patients who either do not have a Primary Care or Specialty Care Provider present or whose acute medical or mental health non-emergent condition requires a higher level of care than is available in the Primary Care or Specialty Care Clinic setting to prevent deterioration or maximize recovery.”⁵ UCCs can exist in facilities with or without an ED and need to have appropriate radiology, laboratory, and pharmacy services available. UCCs do not receive ambulances and are not designed to provide the full spectrum of emergency medical care.⁶

Behavioral Health Programs. Among the U.S. population, an estimated 25 percent of adults experience a MH condition and receive treatment in a given year.⁷ In the 5-year period fiscal years 2006 through 2010, 29 percent of the total veteran population enrolled to receive VA health care received MH care from the VA for conditions including depression, Post-Traumatic Stress Disorder, and substance use disorder (SUD).⁸ VHA medical facilities must provide access to general and specialty MH services when clinically appropriate.⁹ MH services are generally rendered by an interdisciplinary team comprised of providers with prescribing authority (such as, physicians, nurse practitioners, and physician assistants), psychologists, and social workers.¹⁰

VHA policy requires that all first-time patients referred to or requesting MH services receive an initial evaluation within 24 hours and a more comprehensive diagnostic and

³ VHA Directive 2010-010, *Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities*, March 2, 2010. This VHA Directive was in effect during the time frame of the events discussed in this report; it expired on March 31, 2015 and has not been updated.

⁴ Ibid.

⁵ VHA Directive 1079, *Standards for Nomenclature and Operations for Urgent Care Clinics in VA Medical Facilities*, February 2, 2014.

⁶ Ibid; see also VHA Directive 2010-010.

⁷ Mental Illness Facts and Figures, National Alliance on Mental Illness, March 2013.

http://www2.nami.org/factsheets/mentalillness_factsheet.pdf . Accessed December 4, 2015.

⁸ Report to the Ranking Member, Committee on Veterans’ Affairs, House of Representatives, October 2011.

⁹ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008. This VHA Handbook was scheduled for recertification on or before the last working date of September 2013 but has not been recertified; however, a November 16, 2015 amendment modified the time frame for non-urgent mental health care follow-up after an ED visit to 30 days. The handbook, without the amendment, was in effect at the time of our review.

¹⁰ Ibid.

treatment planning evaluation within 14 days.¹¹ Every patient requiring MH services is to be assigned a principal MH provider.¹²

Request for Review. In an April 30, 2015 letter sent to the VA OIG Acting Inspector General, Senator Patty Murray outlined quality of care concerns regarding the ED, MH services, and suicide prevention training at Mann-Grandstaff VAMC, Spokane, WA. The specific requests were:

- Evaluate the steps the facility has taken to recruit and retain ED providers.
- Assess the risk for deficiencies in care as a result of operating hour restrictions on the facility's ED.
- Review a complaint of substandard care that may have contributed to the death by suicide of a patient.
- Evaluate the facility's compliance with suicide prevention training requirements.

Scope and Methodology

The period of review was from April 30, 2015, through September 17, 2015, with an update in May 2016. We reviewed facility documentation, including VHA handbooks and directives, Joint Commission Standards, facility policies and procedures, clinical practice guidelines, electronic health records (EHR), quality management documents, committee minutes, and other relevant documents.

We conducted a site visit June 11–12, 2015. We interviewed the Interim Facility Director, Acting Associate Director, Chief of Staff, and the Associate Director for Patient Care Services. We conducted interviews with program directors (VA Central Office, VISN, and facility level), mid-level managers, providers, and other clinical and administrative staff knowledgeable about the facility's ED, MH, and staff training programs.

In the absence of current VA/VHA policy, we considered previous guidance to be in effect until superseded by an updated or re-certified Directive, Handbook, or other policy document on the same or similar issue(s).

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

¹¹ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

¹² Ibid.

We conducted the inspection 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: Recruitment and Retention

We did not substantiate a failure to actively recruit and retain qualified ED providers.

Historically, the facility staffed the ED with a combination of VA staff physicians and physicians hired through a contract company. From November 2013 to November 2014, the facility lost five ED physician providers mostly due to uncontrollable losses such as resignation, physician request for reassignment to a different clinic, or personnel actions. Both the facility and the contracting company were unable to keep up with the shortfall and meet staffing needs.

VHA requires that an ED Director be board certified in Emergency Medicine, Internal Medicine, Surgery, or Family Practice and have significant Emergency Medicine experience.^{13,14} Recruiting and retaining board certified ED physicians have been long standing challenges for the facility and VHA nationally. Factors contributing to the problem include work schedule, pay, and the ability for emergency medicine trained physicians to acquire and retain emergency medicine skills at a Level 3 facility that treats a majority of patients with low acuity conditions. Although the facility may occasionally have patients present requiring more intensive ED care, those patients are more routinely transferred to one of the local community EDs.

Facility leaders authorized four ED staff physicians and one ED Director for recruitment and hire beginning in December 2013. While the facility has not been successful in hiring new or replacement ED providers, they have been actively recruiting. The facility approached the recruitment challenge using various methods including contracting with a private physician placement service; participating in a local career fair; posting the vacancies in a continuously open status on the USA Jobs website; and placing ads in newspapers for five cities within the region, two professional journals, and five online job search sites. Education debt reduction and relocation incentives have been offered as part of the recruitment package.

Twenty-four applicants applied for one of the four staff ED physician vacancies between January 2014 and May 2015. Of those, 22 withdrew their applications or were not selected, 1 was hired into a non-ED vacancy, and 1 was hired into the ED but has since moved to a non-ED position. Those applicants that withdrew cited personal and/or medical reasons. Facility and VISN 20 human resource staffs monitored the staffing needs of the facility. During the same timeframe, the facility had seven applicants for the ED Director position; two offers were made, but both applicants declined.

¹³ VHA Directive 2010-010, *Standards for Emergency Department and Urgent Care Clinic Staffing Needs in VHA Facilities*, March 2, 2010. This VHA Directive expired on March 31, 2015 and has not been updated.

¹⁴ Board certification is a voluntary process and very different from medical licensure. Obtaining a medical license establishes the minimum competency requirements to diagnose and treat patients and is not specialty specific. Board Certification demonstrates a physician's expertise in a particular specialty or subspecialty of medical practice.

As of May 2016, the facility is staffing the UCC with contract staff, as they have been unable to successfully fill any of the vacant positions despite ongoing recruitment efforts.

Issue 2: Change in ED Operating Hours

We did not substantiate that the facility's change from an ED to UCC with a reduction in operating hours resulted in a deficiency in care.

Effective December 1, 2014, due to reported physician staffing challenges, the facility changed the status of the ED to a UCC to align the delivery of care with available staff and resources thereby reducing the potential for adverse events. Because of its Level 3 complexity designation, the facility serves lower risk medical and surgical patients. Whether contract or VA employed, ED physicians reported it was difficult to maintain required skills at a Level 3 complexity facility and most were seeking a higher risk complexity facility.

In accordance with VHA's UCC policy,¹⁵ the facility director set the operating hours to less than 24 hours with UCC operation hours from 8 a.m. to 6 p.m. every day, including holidays. Prior to implementing the change, facility leaders formed a group to perform an in-depth analysis of ED staffing, daily census, patient acuity,¹⁶ type of patients seen, and care provided between January and November 2014. Facility leaders reported that on average, the ED provided care for 60 patients per week day and 15 patients per weekend day. Typically two to three patients sought care during the night. Complicated cases that exceeded the facility's Level 3 complexity level, such as stroke and trauma, were transferred out to community hospitals. Prior to the change, the facility ED transferred, on average, 14 to 15 patients to community hospitals via ambulance per month.

Following the change from an ED to UCC and a reduction in operating hours, the facility remained able to address the medical care needs of patients presenting for care except for a small number with a high level of medical complexity that continued to be transferred out to community hospitals. Facility leaders and ED program managers reported the average number of patients remained constant. Adjustments in staffing levels occurred to accommodate the volume of patients within the reduced hours. The median elapsed time for all UCC visits measured from the time of check in to the time of departure remained stable over the past year and are below the threshold set by VHA. Further, facility leaders directed a night shift administrator to track all patients who attempted to access care after the UCC closed for the day. The purpose of this was twofold: to determine the effectiveness of the facility's efforts to educate and inform patients on the change in hours and to administratively track any adverse events that

¹⁵ VHA Directive 1079, *Standards for Nomenclature and Operations for Urgent Care Clinics in VA Medical Facilities*, February 2, 2014.

¹⁶ Acuity is defined as the measure of the intensity of care required by a patient and is used in the health care setting to determine the number of staff needed to provide safe patient care.

may have occurred after the UCC closed for the day. ED program managers reported that to their knowledge, no afterhours UCC access attempts had resulted in an adverse outcome. We reviewed quantitative information comparing data before and after the designation change. The data showed that the average number of patients remained constant, the facility was able to efficiently care for the patients, and ambulance transfers to the community increased by only one to three per month. We found no change in medical admissions, the number of surgeries performed, or use of other services within the facility.

Issue 3: Patient Death by Suicide

We did not substantiate that quality of care issues contributed to the death by suicide of a patient.

Patient Case Summary

The patient was in his 30s with multiple medical and mental health diagnoses when he was admitted to the facility in 2013 for a surgical procedure. During the hospitalization, facility staff documented that the patient displayed episodes of anger, anxiety, and sleeplessness. The patient was evaluated by inpatient MH staff and started on an anti-depressant. The patient was discharged on pain medication containing a narcotic as needed for post-surgery pain and instructed to follow up with his primary care provider if additional MH services were needed. The PCP provider saw the patient 5 days after discharge and submitted a consult for MH services. The patient was evaluated by a MH provider approximately 2 weeks later.

Two days after the MH evaluation, the patient presented to his primary care provider requesting narcotic pain medication. The primary care provider recommended the use of non-narcotic pain medications; the patient was not in agreement with this decision and presented to the facility ED later the same day requesting narcotic pain medication. The ED provider note described the patient as anxious with "...thoughts of killing himself" but with no specific plan for suicide. The treatment plan was to admit the patient to the inpatient psychiatry unit at the facility; however, a bed was not immediately available. The patient remained in the ED overnight. The following day, staff arranged for admission to another inpatient MH unit but the patient declined. The facility MH Consultant examined the patient in the ED and determined that he was not at risk for suicide or self-harm and, therefore, not a candidate for an involuntary hold. Arrangements were made for the patient to follow up with the outpatient MH clinic, and the patient was discharged home.

Approximately 2½ months later, the patient was again seen in the facility ED. The ED provider documented that the patient was suicidal, and complaining of chronic pain. The patient was admitted to the inpatient MH unit. Suicide risk assessments were completed upon admission and every day during this 10-day hospitalization. Each assessment documented him to be "not at risk" for suicide. The suicide risk assessment completed on the day of discharge was consistent with the previous findings of "not at risk." By discharge, the patient was noted to be "sleeping

adequately,” had “substantially improved mood,” and consistently denied suicidal ideation since the mid-point of his hospital stay. Discharge planning included an option for immediate entry into an outpatient program. The patient initially accepted enrollment in a non-local program but subsequently declined. He was offered written discharge instructions for his medications, the telephone number for the veteran’s crisis line, and a letter with the date and time of his outpatient appointments but declined to take the paperwork with him.

Within 48 hours of discharge, facility staff contacted the patient by phone to see how he was doing. He described “having less pain and more energy.” Approximately 1 month after discharge, the patient was seen by an outpatient psychiatrist. At that time, the patient described himself as “doing well” and desiring only to have his medications refilled. The patient was given prescriptions for his medications and told to follow up in 3 months. In the month following his outpatient psychiatric appointment, the patient was in contact with the facility MH clinic to include requesting a refill of his medications.

In early 2014, facility staff were notified that the patient was homeless. Facility staff consulted with the one of the facility’s homeless coordinators to initiate the process of obtaining housing for the patient. Securing housing required the patient to participate in facility sponsored group or individual outpatient preparation sessions. The patient began to regularly attend these sessions, and documentation in the EHR described the patient as “engaged” in group discussions. After attending three group sessions, the patient called to say he was unable to attend that day due to a lack of transportation. Facility staff were telephonically notified the following day that the patient was staying in a local hotel. The patient’s exact location and contact information was not provided. Ten days later, the facility was notified of the patient’s death from an apparent suicide.

Discussion

Suicide is the tenth leading cause of death overall and fourth among 25 to 44 year olds.¹⁷ Suicide risk is dynamic and suicide risk assessment is not absolute. Many factors influence an individual’s risk of suicide at any given point in time. Illnesses or stressful life events increase vulnerability to suicidal thoughts.¹⁸ A person may cross a threshold and act on suicidal impulses when they experience some event that seems to make life unlivable.¹⁹ Early identification of suicidal ideation presents the greatest opportunity to reduce the risk of suicide attempt and death.²⁰ The use of evidence based clinical practice guidelines, a uniform approach to risk assessment, and effective treatment by skilled MH practitioners provides the best opportunity for reducing the risk of suicide.

¹⁷ Suicide: 2015 Facts and Figures American Foundation for Suicide Prevention, released Fall 2014.

¹⁸ VA/DoD *Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide*, Version 1.0, June 2013.

¹⁹ Ibid.

²⁰ Ibid.

The patient was evaluated on multiple occasions in 2013 by MH providers, in both in the inpatient and outpatient settings, who assessed the patient for risk of suicide. At the time of the hospitalization for his surgical procedure, he was found to be “not a risk” for suicide. During his first outpatient visit after his surgery, and subsequent appointments in the outpatient MH clinic, the patient was found to be not at risk for self-harm. Over the next few months, facility staff offered the patient various outpatient program options which he declined.

Pain management played an important role in the patient’s MH and medical plan of care. He was initially treated with a variety of narcotic analgesics for several painful medical and surgical conditions, but as a result of coordinated efforts by the patient and his various providers, he was slowly transitioned to a combination of non-narcotic medications and smaller doses of narcotic pain medications.

Homelessness and the associated economic instability have been identified as risk factors for suicide.²¹ In 2014, the patient was without permanent and stable housing. Securing housing required the patient to participate in facility sponsored group or individual outpatient preparation sessions and he began to regularly participate in those sessions. After three sessions, however, the patient no longer had reliable transportation and was unable to attend. Due to the lack of stable housing and reliable contact information, facility staff were unable to communicate with the patient after he missed one of his preparation sessions.

We found that MH services provided were consistent with VHA directives and policies.²²

Issue 4: Suicide Prevention Training

We substantiated that facility leaders failed to comply with VHA requirements for suicide prevention training.

In 2007, Congress passed the Joshua Omvig Veterans Suicide Prevention Act, which directed VA to create a comprehensive suicide prevention program to address suicide among the veteran population. VHA developed a web-based learning program to educate health care providers on suicide risks as well as interventions or strategies for suicide prevention. VHA policy requires designated health care providers to complete the Suicide Risk Assessment for Clinicians course within 90 days of hire.²³ For the

²¹ Matarazzo, BB, Farro, SA. *Suicide: Homelessness, Risk Assessment and Safety Planning*. VISN 19 Mental Illnesses, Research, Education and Clinical Center; University of Colorado, School of Medicine, Department of Psychiatry, 2014.

²² VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008; VHA Handbook 1162.05, *Housing and Urban Development (HUD)-Department of Veterans Affairs Supported Housing (VASH) Program*, September 14, 2011.

²³ VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, June 27, 2014; a similar requirement was present in the previous VHA Directive addressing suicide prevention training, VHA Directive 2008-051, *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, August 28, 2008.

purpose of this training requirement, VHA policy defines a health care provider as a “full-time, part-time or intermittent employee engaged in patient care as a physician, Psychologist, Registered Nurse, Social Worker, Physician’s Assistant, Pharmacist or Dentist as well as any employee serving in the capacity of Case Manager or Vet Center Team leader or Counselor.”²⁴

VHA also requires that each VA Medical Center appoint and maintain a SPC with a full-time commitment to suicide prevention activities. The SPC’s duties include responding to reports about suicide attempts and working with providers to ensure intensified monitoring and treatment for high-risk patients. The SPC is also required to provide and track training of all VA staff who have contact with patients, including clerks, schedulers, and those who are in telephone contact with veterans, on how to get immediate help when veterans express any suicide plan or intent.²⁵

Upon hire at the facility, new employees are given an online education account in the Talent Management System. Based on the employee’s job classification and work assignment, a training profile is created that identifies mandatory training requirements and establishes specific timelines for completion. Employees are able to access the required training modules online 24 hours a day, 7 days a week, and supervisors can obtain information on the training completion status for each of their subordinate employees. At the initiation of our review, the mandatory suicide risk and intervention training was not assigned to the required clinicians. We found that the SPC was aware that over half of the designated health care providers throughout the facility had not completed the Suicide Risk Assessment for Clinicians course within the first 90 days of hire as required. Within Mental Health Service, 23 of 64 employees had not completed the training. We also found that the SPC had discussed this with leaders in the departments of MH and education. The facility lacked a process to assign the required training, to notify the designated employees of the required training and to alert supervisors when the training was not completed.

On June 25, 2015, the training was assigned in the Talent Management System to all applicable clinicians. As of July 13, 2015, a total of 328 had completed the training and 210 had not. Only three staff were delinquent in completion of the training as of May 17, 2016.

Conclusions

We did not substantiate a failure to actively recruit and retain qualified ED providers. We did not substantiate that the facility’s change from an ED to UCC and a reduction in operating hours resulted in a deficiency in care. We determined that the facility was thoughtful in planning their approach to align the delivery of care with resources thereby

²⁴ VHA Directive 1071, *Mandatory Suicide Risk and Intervention Training for VHA Health Care Providers*, June 27, 2014.

²⁵ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

reducing the potential for adverse events after the loss of ED providers. Facility leaders took steps to inform the public before changing to a UCC and tracked after-hour attempts to access care once the change occurred.

We did not substantiate that quality of care issues contributed to the death by suicide of a patient. MH services provided were consistent with VHA directives and policies.

We substantiated that facility leaders failed to comply with VHA requirements for suicide prevention training. The training was assigned on June 25, 2015 in the Talent Management System to all applicable clinicians, and as of May 17, 2016, only three staff remained delinquent in completion of the training. We determined the facility lacked a process to ensure that all required training is assigned to applicable staff, compliance is monitored, and reporting of overall compliance takes place at a facility-wide level.

Recommendation

1. We recommended that the Interim Facility Director strengthen processes to ensure suicide prevention training is completed per Veterans Health Administration Directive 1071 and monitor compliance.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 8, 2015

From: Director, Northwest Network VISN 20 (10N20)

Subj: Healthcare Inspection—Emergency Department, Mental Health Service, and Suicide Prevention Training Concerns, Mann-Grandstaff VAMC, Spokane, Washington

To: Director, Seattle Office of Healthcare Inspections (54SE)
Director, Management Review Service (VHA 10E1D MRS Action)

1. Thank you for the opportunity to provide responses to the findings from the Healthcare Inspection-Emergency Department, Mental Health Service, and Suicide Prevention Training Concerns at the Mann-Grandstaff VAMC, Spokane, Washington.
2. Attached please find the facility concurrence and response to the findings from the review.
3. If you have additional questions or need further information, please contact Susan Green, Survey Coordinator, VISN 20 at (360) 567-4678.

(original signed by:)
Lawrence H. Carroll

Interim Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 3, 2015

From: Interim Medical Center Director, Mann-Grandstaff VA Medical Center (668/00)

Subj: Healthcare Inspection—Emergency Department, Mental Health Service, and Suicide Prevention Training Concerns, Mann-Grandstaff VAMC, Spokane, Washington

To: Director, Northwest Network VISN 20 (10N20)

1. Please find the attached status report on the follow-up to the findings from the Emergency Department, Mental Health Service, and Suicide Prevention Training Concerns at the Mann-Grandstaff VAMC, Spokane, Washington during the week of June 11-12, 2015.
2. The Mann-Grandstaff VAMC staff is committed to continuously improving processes and care provided to our veterans and have worked to correct the recommendations identified in the attached report.
3. If you have additional questions, or need additional information, please contact Betty Braddock at 509-424-73600.


J. Ronald Johnson, FACHE

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendation

Recommendation 1. We recommended that the Interim Facility Director strengthen processes to ensure suicide prevention training is completed per Veterans Health Administration Directive 1071 and monitor compliance.

Concur

Target date for completion: Closed at time of publication

Facility response:

In collaboration with the Learning Center staff, the Suicide Prevention Coordinator (SPC) established a process that monitors completion of training required by VHA Directive 1071. Currently, the Mann-Grandstaff VAMC has a compliance rate of 96.5% (524/543), and is committed to reaching 100% by January 29, 2016.

A direct method of reminding appropriate staff to take their training has been initiated. The staff and their supervisors are reminded through notifications from the TMS. The training remains on their "to do" list in TMS until it has been completed.

Learning Center staff is running a compliance report the first week of each month to assess for compliance of required training. This report is shared with Leadership during morning report. Additionally, the list of staff names not having completed the required training is given to the Service Chief for follow-up.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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