



DEPARTMENT OF VETERANS AFFAIRS  
**OFFICE OF INSPECTOR GENERAL**

*Office of Healthcare Inspections*

VETERANS HEALTH ADMINISTRATION

Deficiencies in Emergency  
Department Care for a  
Patient Who Died by Suicide  
at the John Cochran Division  
of the VA St. Louis Health  
Care System in Missouri



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## Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate the care provided to a patient who died by suicide in the [Emergency Department](#) at the John Cochran Division of the VA St. Louis Health Care System (facility) in Missouri.

### Synopsis of Events

The patient was in their 60s with a history of an [enlarged prostate](#), substance use, depression, [posttraumatic stress disorder](#), and suicide attempts.<sup>1</sup> Since 2001, the patient had been receiving health care at the facility and had multiple admissions for suicidal thoughts and substance use.

In early fall 2021, at 5:14 a.m., the patient presented to the facility's Emergency Department complaining of [urinary retention](#) and depression. An Emergency Department charge nurse (Nurse 1) [triaged](#) the patient and documented the patient reported "substance abuse of unknown amount," the patient's statement, "I don't want to die" and described the patient as being depressed and feeling "dissatisfied with life." The [problem list](#) in Nurse 1's triage note included the patient's history of substance abuse and deliberate self-harm. Nurse 1 conducted a required suicide risk screen during triage and documented the patient's screen as negative. The patient's vital signs were normal, with the exception of an elevated blood pressure. Nurse 1 assigned the patient an [Emergency Severity Index](#) level 3 and moved the patient to an exam room.<sup>2</sup>

At 5:30 a.m., Nurse 1 documented that an Emergency Department physician (physician) was notified of the patient's arrival and directed an Emergency Department nurse (Nurse 2) to complete a [bladder scan](#) on the patient. At 6:15 a.m., Nurse 1 documented that the patient was still pending physician evaluation and intervention. At 7:30 a.m., Nurse 1 provided a report to the incoming day-shift Emergency Department nurse.

At 7:37 a.m., an Emergency Department technician found the patient unresponsive on the floor of the exam room in a kneeling position between a supply cart and a wall. Emergency Department staff initiated [cardiopulmonary resuscitation](#) and followed [advanced cardiac life support](#) protocols. Resuscitation efforts were unsuccessful, and an incoming day-shift Emergency Department physician pronounced the patient's death at 7:49 a.m. An Emergency Department nurse, who assisted in attempting to resuscitate the patient, documented that the

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<sup>1</sup> The OIG uses the singular form of they (their) in this instance for privacy purposes. The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

<sup>2</sup> Emergency Nurses Association, *Emergency Severity Index: A Triage Tool for Emergency Department Care*, Version 4, 2020 Edition. A patient assigned a level 3 triage category is considered to be stable with no acute risk or immediate threat to life. Emergency Department nurses base this categorization on a patient's stability and the number of resources, such as medications, procedures, and laboratory or radiology studies required to evaluate the patient.

patient appeared to have a “[ligature](#) mark to the neck.” The chief of the Emergency Department documented that the patient had “evidently formed a ligature” from the exam room’s [ophthalmoscope](#) cord. A medical examiner conducted an autopsy and confirmed that the patient died by suicide as a result of hanging.

## Inspection Results

### Deficiencies in Quality of Care

The OIG determined that deficiencies in the quality of Emergency Department care provided to the patient resulted in a delay of care and may have contributed to the patient’s death.<sup>3</sup> The OIG identified three areas of deficiencies:

- Administration of the suicide risk screen
- Absence of a physician evaluation of the patient
- Failure to monitor the patient

The OIG found that Nurse 1 may not have properly administered a standardized suicide risk screen while triaging the patient, which may have impacted the accuracy of the result. The suicide risk screening tool is embedded within the electronic health record (EHR) Emergency Department triage note and is required to be completed at every Emergency Department visit. The tool identifies patients who require an in-depth follow-up risk evaluation along with more direct one-to-one observation during their Emergency Department visit. The Joint Commission emphasizes that the wording of the questions in a suicide risk screening tool should not be changed in any way, as even a small change could affect accuracy.<sup>4</sup>

Following the patient’s suicide, the facility leaders conducted an [administrative investigation](#) of the event. Nurse 1 documented a negative suicide risk screen in the triage note, and that the patient answered “no” to suicide risk screen questions that assessed recent and prior thoughts of suicide. According to the administrative investigation report, Nurse 1 did not utilize the computer in the triage room and asked the patient suicide risk screen questions from memory. However, during the administrative investigation, Nurse 1 was unable to recall the suicide risk screen questions upon request. Based on Nurse 1’s inability to recite the suicide risk screen from memory, the OIG questions the accuracy of the patient’s negative suicide risk screen but could not determine whether administering the suicide risk screen as intended would have resulted in a different outcome.

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<sup>3</sup> Information contained within the inspection results originates from the facility’s administrative investigation, interviews with facility staff, and the patient’s EHR. For brevity, attribution is only provided when necessary to identify the specific source of the information.

<sup>4</sup> The Joint Commission, *R<sup>3</sup> Report*, “National Patient Safety Goal for Suicide Prevention,” November 20, 2019.

The OIG found that over two hours and twenty minutes elapsed from the time the patient arrived in the Emergency Department to the time the patient was found unresponsive. The Veterans Health Administration (VHA) uses a “[Door to Doc](#)” metric, which defines national performance goals for patient wait time from arrival in an emergency department to being assigned to a provider and evaluated.<sup>5</sup> The national target “Door to Doc” time is less than or equal to 25 minutes.<sup>6</sup>

The OIG determined that the first issue contributing to the delay was Nurse 1’s failure to communicate to the physician that the patient was awaiting evaluation. Contrary to Nurse 1’s EHR documentation that the physician was notified of the awaiting patient, the facility administrative investigation report cited video footage that did not support Nurse 1 going to the location where the physician was resting.<sup>7</sup> The patient’s care was further delayed as a result of the failure of the physician to respond to an alert by Nurse 2 about an hour after the patient’s presentation to the Emergency Department that patients were waiting to be seen. During an interview with the OIG, Nurse 2 recalled notifying the physician that there were two patients awaiting evaluation. The physician acknowledged receiving the notification by Nurse 2 but did not immediately respond, being “slow to move” from the effects of a vaccine he recently received. Nurse 1’s failure to alert the physician and the physician’s failure to respond to the notification by Nurse 2 caused a delay in the patient receiving timely clinical and mental health evaluations and interventions. The OIG is unable to determine the exact time of the patient’s suicide. However, had Nurse 1 notified the physician after placing the patient in an exam room and had the physician responded to Nurse 2’s alert, the physician may have evaluated the patient and recognized the need for more urgent or intensive mental health treatment.

The OIG found that Nurse 1 failed to monitor the patient after triage.<sup>8</sup> In an interview with the OIG, and noted in the administrative investigation report, Nurse 1 reported having no further contact with the patient after placing the patient in the exam room and prior to giving an end-of-shift report at 7:30 a.m. to the incoming Emergency Department nurse. The facility administrative investigation determined that after Nurse 2 completed the bladder scan at

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<sup>5</sup> VHA Support Service Center Manual, “Emergency Medicine Management Tool.” Door to Doc time is defined as the time in minutes between patient arrival and the assignment of a physician to a patient. The assignment should occur just prior to the provider’s review of a patient’s chart or patient evaluation.

<sup>6</sup> VHA Support Service Center Manual, “Emergency Medicine Management Tool.”

<sup>7</sup> Despite multiple requests, facility staff was unable to provide the OIG with the exact copy of the video footage viewed by the administrative investigation members to support the finding. Therefore, the OIG could not independently verify the administrative investigation’s conclusion that Nurse 1 did not notify the physician of the patient’s arrival. The interview with the administrative investigation chair, however, well supported that the video footage did not support Nurse 1’s description of events.

<sup>8</sup> Facility Standard Operating Procedures 118-40, “Nursing Process and Documentation,” July 31, 2019. Nursing staff are required to monitor the vital signs of Emergency Department patients who are triaged as an Emergency Severity Index level 3 every two hours.

approximately 5:19 a.m., no further contact was made with the patient by Emergency Department staff until the patient was found unresponsive at 7:38 a.m. At the time of the OIG inspection, Emergency Department leaders had not published a written policy that outlined the required frequency of patient rounding. The Emergency Department nurse manager told the OIG that [hourly rounding](#) on patients is expected, but at the time of the OIG inspection, there was no written policy outlining the required frequency of patient rounding. The failure of Nurse 1 to provide continued monitoring during the patient's Emergency Department stay represents an additional missed opportunity to identify potential changes in the clinical and mental health status of the patient.

### **Deficiencies in Facility Leaders' Response**

The OIG determined that facility leaders took action in response to the patient's death by conducting a root cause analysis (RCA), an administrative investigation, and [peer reviews](#).<sup>9</sup> However, the OIG found deficiencies related to the RCA process. Additionally, facility leaders failed to complete a timely institutional disclosure and failed to report Nurse 1 to state licensing boards (SLB).

The OIG found that the facility leaders did not conduct a thorough RCA review of the event by failing to include an Emergency Department subject matter expert as part of the RCA team. The RCA charter, signed by the facility's Deputy Executive Director, identified that the RCA team include an Emergency Department provider. However, according to the final RCA report presented to facility leaders, the RCA team did not include an Emergency Department provider. Despite concerns raised by RCA team members regarding proceeding without an Emergency Department provider as a team member, a patient safety program manager told the OIG that facility leaders instructed the RCA team to continue with the review. The facility's Chief of Staff and the director of Quality, Safety, Value, and High Reliability (QSVHR) did not provide the OIG with any further explanation of why an Emergency Department provider was not included on the team. The inclusion of identified subject matter experts on RCA teams is needed to fully evaluate potential system and process breakdowns that may contribute to events. The failure to ensure the RCA team included all identified subject matter experts negatively impacted the team's ability to conduct a sufficient review.

The OIG learned from the Chief of Staff that a decision was also made to initiate an administrative investigation to be conducted by a separate team while the RCA was in progress. The OIG found that the initiation of an administrative investigation led to confusion among the RCA team in regard to the process of conducting the review without interfering with the administrative investigation. Despite VHA requiring individuals directly involved in events to be

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<sup>9</sup> The OIG reviewed peer reviews completed on all relevant clinical staff and found no deficiencies in the findings, process, or procedure.

interviewed, the RCA team did not interview individuals directly involved with the event or other staff with experience and knowledge of the Emergency Department. During an interview with the OIG, an RCA team member reported that the team was “not allowed” to interview staff and instead had to focus the review on the information available in the patient’s EHR. However, the director of QSVHR told the OIG that the RCA team was not given any restrictions while conducting the review and had the same information as the administrative investigation. This confusion contributed to the RCA team failing to interview staff directly involved in the patient’s care or other staff who were experienced and knowledgeable in the processes of the Emergency Department. Without input from staff involved in Emergency Department processes, the identification of potential root causes can be incomplete and limit the utility of the RCA in preventing the same or similar event.

The OIG found that facility leaders did not complete a timely institutional disclosure to the patient’s family related to the patient’s death in early fall 2021. Facility leaders are responsible for initiating an institutional disclosure “as soon as reasonably possible” after an event and “generally within 72 hours.”<sup>10</sup> The Chief of Staff told the OIG that an institutional disclosure was not completed at the time of the patient’s death and that a Veterans Integrated Service Network risk management review in early spring 2022 first identified the need for an institutional disclosure. In mid-spring 2022, the Chief of Staff made the first attempt to contact the patient’s family to complete the institutional disclosure. The Chief of Staff documented in the EHR contacting the patient’s family in late spring 2022, to again offer an institutional disclosure. As of early fall 2022, an institutional disclosure with the patient’s family had not been completed and documented in the EHR.<sup>11</sup> The Chief of Staff told the OIG that facility leaders’ initial focus on the RCA and administrative investigation contributed to the failure to complete an institutional disclosure immediately after the event. The OIG concluded that although attempts by the Chief of Staff to contact the patient’s family were made, approximately seven months elapsed after the patient’s death before the Chief of Staff made the first attempt. The failure to complete an institutional disclosure timely represents a missed opportunity to inform a patient’s family or representatives about significant facts regarding an event and has the potential to erode the trust that patients and their families have in their healthcare system.

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<sup>10</sup> VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 10, 2018.

<sup>11</sup> VHA Directive 1004.08. Facility leaders are required to document completion of an institutional disclosure in the EHR.

The OIG found that facility leaders did not comply with VHA requirements for reporting Nurse 1 to the SLBs in the three states in which the nurse was actively licensed.<sup>12</sup> According to VHA policy, facility staff are required to initiate SLB reporting for any licensed healthcare professional who fails to meet accepted standards of behavior or clinical practice.<sup>13</sup> Facility leaders initiated an administrative investigation to review allegations that Nurse 1 demonstrated “potential inadequate to inappropriate ED [Emergency Department] nurse professional and clinical actions, judgments, and/or decisions” in the care of the patient who completed suicide in the Emergency Department. Nurse 1 resigned from the facility over one month prior to the completion of the administrative investigation. Although the administrative investigation had not been completed, a [Provider Exit Review](#) form signed by Nurse 1’s supervisors documented the reason for the nurse leaving as “resigned/retired” instead of “resigned while under investigation” and noted that SLB reporting was not indicated. Nurse 1’s supervisors reported to the OIG that this decision was based on an understanding that the scope of the investigation focused on the event and not concerns specific to Nurse 1. Upon completion, the administrative investigation found that Nurse 1 failed to meet the standards of care for the “medical center and State Board.” Based on the findings, the administrative investigation report recommended that “adverse action” be taken against Nurse 1 in accordance with the Title 38 Table of Penalties for offenses, including “endangering the safety of or causing injury to anyone on VA premises.”<sup>14</sup> Despite the administrative investigation recommendation based on the evidence, the Facility Director and the Associate Director for Patient Care Services elected to take no further actions against Nurse 1, including reporting to the SLBs. The rationale stated by the Facility Director and the Associate Director for Patient Care Services was that reporting was not required based on the classification of Nurse 1’s deficiencies in care as conduct, not clinical competency. The OIG determined that the Facility Director and the Associate Director for Patient Care Services failed to comply with VHA policy when determining whether to initiate SLB reports for Nurse 1, representing a missed opportunity to ensure that a healthcare professional, who was found by an administrative investigation to have failed to meet the standard of care and endangered patient safety, was

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<sup>12</sup> VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021. SLBs are responsible for authorizing healthcare professionals to provide healthcare services. An SLB may or may not undertake additional formal proceedings against a healthcare professional’s license after receiving a report from VHA regarding concerns with the professional’s clinical practice. Based on the evidence reviewed, the OIG did not find that VHA Handbook 1100.18 required facility leaders to report the Emergency Department physician, who was a contract employee. The policy requires reporting to SLBs when a provider is removed from a contract following the completion of a disciplinary action; however, the evidence does not support that facility leaders took any disciplinary action, only that the facility terminated the contract. Further, although the VA has broad authority to report a provider whose behavior or clinical practice raises reasonable concern for the safety of patients, according to the provider’s exit review and the administrative investigation findings, this was not substantiated.

<sup>13</sup> VHA Handbook 1100.18.

<sup>14</sup> VHA Directive 5021/15, *Employee/Management Relations*, Part I, Appendix A, “Range of Penalties for Stated Offenses,” July 19, 2013.

appropriately reported to the SLBs. The OIG also identified a concern related to the chief of the Emergency Department's conduct attempting to direct staff responses during the OIG inspection.

The OIG made six recommendations to the Facility Director related to the appropriateness of the chief of the Emergency Department's conduct during the OIG inspection; the administration of the suicide risk screen; expectations for monitoring Emergency Department patients; completion of RCA and administrative investigations on the same event; completion of institutional disclosures within required time frames; and compliance with SLB reporting.

## **VA Comments**

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



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## Abbreviations

ADPCS	Associate Director for Patient Care Services
EHR	electronic health record
OIG	Office of Inspector General
QSVHR	Quality, Safety, Value, and High Reliability
RCA	root cause analysis
SLB	state licensing board
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



## Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate the care provided to a patient who died by suicide in the [Emergency Department](#) at the John Cochran Division of the VA St. Louis Health Care System (facility) in Missouri.<sup>1</sup>

## Background

The facility is part of Veterans Integrated Service Network (VISN) 15, with two divisions and multiple outpatient clinics in Illinois and Missouri. Classified as a level 1a complexity facility, the John Cochran Division provides full-service inpatient care for medicine and surgery services, outpatient psychiatric care, as well as over 65 other subspecialties.<sup>2</sup> The Jefferson Barracks Division provides psychiatric treatment, spinal cord injury treatment, geriatric care, and a rehabilitation domiciliary program for homeless veterans. From October 1, 2020, through September 30, 2021, the facility served 62,755 patients and had a total of 337 operating beds. Within the same time frame, the Emergency Department contained 14 beds and served 21,604 patients.

## Allegations and Related Concerns

On October 4, 2021, the OIG received a complaint alleging that a patient presented to the facility's Emergency Department and was found unresponsive approximately two hours later. On October 19, 2021, the Office of Healthcare Inspections reviewed the complaint and referred the case to the VISN on November 10, 2021, for additional information and response. The OIG received the VISN response on January 27, 2022, and determined the response was inadequate and did not address the allegations. On February 8, 2022, the OIG opened a healthcare inspection to assess deficiencies in quality of care and leadership failures related to the event.

## Concerns of Interference with Inspection

On October 27, 2022, the Office of Accountability and Whistleblower Protection (OAWP) provided the OIG with a copy of an email that had been sent by the chief of the Emergency Department to a staff Emergency Department physician.<sup>3</sup> OAWP had discovered the March 17, 2022, email during an unrelated OAWP investigation, and expressed concern that the email

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<sup>1</sup> The underlined terms are hyperlinks to a glossary. To return from the glossary, press and hold the "alt" and "left arrow" keys together.

<sup>2</sup> VHA Office of Productivity, Efficiency, and Staffing. The Facility Complexity Model classifies VHA facilities at levels 1a, 1b, 1c, 2, or 3 with level 1a being the most complex and level 3 being the least complex. Level 1a facilities are considered the most complex.

<sup>3</sup> This report provides no information relating to OAWP's source in receipt of the email.

suggested there may have been interference with the OIG inspection. The email, which referenced the OIG inspection, stated in part:

. . . everybody needs to know this is **NOT** the opportunity to air grievances. The IG will be trolling for evidence of leadership and administrative malfeasance that allowed a veteran to kill himself in our ED [Emergency Department]. Appropriate responses to direct questions are: yes, no, I don't know, and I don't remember. BOOM!

On receipt of the email from OAWP, the OIG re-interviewed 11 individuals to assist in determining whether the chief's message had impacted any of the interviewees' responses. In addition to the interviews, the OIG conducted an email search and discovered one additional email that had been sent by the chief of the Emergency Department to another Emergency Department physician with a message similar to the above message, directing responses to OIG questions.

Federal regulations provide that an employee shall not engage in conduct prejudicial to the Government.<sup>4</sup> Standards of Ethical Conduct for Employees of the Executive Branch state that an employee has a responsibility to "place loyalty to the Constitution, laws, and ethical principles above private gain" and shall "act impartially and not give preferential treatment to any private organization or individual."<sup>5</sup>

Although the OIG determined the evidence did not support that the email messages impacted the credibility of the inspection findings, the OIG finds an attempt to direct staff responses during an OIG inspection to be inconsistent with the intent of the federal regulations and Ethical Code of Conduct, and recommends the facility conduct an investigation of alleged interference with the inspection.

## Scope and Methodology

The OIG initiated the inspection on February 8, 2022, and conducted a site visit March 29–31, 2022.

The OIG interviewed the facility's Chief of Staff as well as a Quality, Safety, Value, and High Reliability (QSVHR) leader and Emergency Department leaders; current and former medical providers, nursing staff, and administrative staff involved in the patient's care; the facility risk manager and a patient safety manager; the facility suicide prevention case manager and coordinator; and the chief of social work and a social work staff member.

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<sup>4</sup> 5 CFR § 735.203.

<sup>5</sup> 5 CFR § 2635.101.

The OIG reviewed the patient's electronic health record (EHR) from early through mid-2021. The OIG also reviewed relevant Veterans Health Administration (VHA) and facility policies; a facility [administrative investigation](#), quality management reviews and responses, and human resource documents; and VA police reports related to the event.

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 (IG) Act of 1978, as amended, 5 U.S.C. §§ 401–24. 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 was in their 60s with a past medical history of an [enlarged prostate](#), substance use, depression, and [posttraumatic stress disorder](#).<sup>6</sup> The patient had been receiving health care at the facility since 2001, had multiple admissions for diagnoses of suicidal thoughts and substance use from 2001 through 2020, and had a history of suicide attempts. The patient also had a history of chronic neck pain and [spinal stenosis](#). While the patient had been evaluated by a neurosurgeon and surgical intervention had been scheduled for early spring 2021, the surgery was canceled due to the patient's cocaine use. The patient had previously experienced incarceration and homelessness but received housing and social work services through the facility's homeless program.

In early 2021, the patient visited a facility psychiatrist, from whom the patient had been receiving psychiatric care since 2017, with complaints of low mood, cocaine use, and suicidal thoughts. The psychiatrist documented a positive Columbia-Suicide Severity Rating Scale screen

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<sup>6</sup> The OIG uses the singular form of they (their) in this instance for privacy purposes.

(suicide risk) and completed a follow-up Comprehensive Suicide Risk Evaluation.<sup>7</sup> The psychiatrist updated the patient's suicide safety plan, issued the patient a copy of the plan, and referred the patient to the suicide prevention team.<sup>8</sup> A suicide prevention case manager activated a high risk for suicide flag the next day.<sup>9</sup>

Three months later, the suicide prevention case manager entered a note that the patient's high risk for suicide flag was due for a 90-day review.<sup>10</sup> The high risk flag committee reviewed the patient's EHR with input from the patient's providers. The high risk for suicide flag was continued at that time due to the patient's recent [suicidal ideation](#) and substance abuse, and because the patient had not been engaged in treatment. Three months later, the suicide prevention case manager entered a progress note indicating that the patient's high risk for suicide flag was again due for a 90-day review. The facility psychiatrist noted that the patient's "chronic risk [of suicide] remains high, but [the patient] does not appear to be at elevated subacute risk at this time."<sup>11</sup> A facility social worker concurred with the psychiatrist. Two weeks later, the suicide prevention case manager documented that the high risk flag committee had reviewed the patient's high risk for suicide flag and recommended inactivating the flag since the patient had re-engaged with treatment and "denied intention, plan, or recent preparation" for suicide. The high risk for suicide flag was inactivated that day.<sup>12</sup> The suicide prevention team sent a letter to the patient stating that the high risk for suicide flag had been inactivated, encouraged the patient

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<sup>7</sup> The Columbia Lighthouse Project, "About the Protocol," accessed May 11, 2022, <https://cssrs.columbia.edu/the-columbia-scale-c-srs/about-the-scale/>. The Columbia-Suicide Severity Rating Scale is a protocol used to assess an individual's risk for suicide as well as determine the severity of the risk and evaluate the level of support an individual may need. Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer, *Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation (Risk ID Strategy)*, November 10, 2020. When a patient has a positive Columbia-Suicide Severity Rating Scale screen, a follow-up Comprehensive Suicide Risk Evaluation is expected to be completed the same day. The Comprehensive Suicide Risk Evaluation assists health care providers in assessing a patient's level of suicide risk in order to inform risk management.

<sup>8</sup> VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021. A suicide safety plan is a "prioritized written list of coping strategies and sources of support developed in collaboration with patients that can be used before or during suicidal crises," a is intended to be used by patients to help them "lower their imminent risk of suicidal behavior."

<sup>9</sup> VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. "The primary purpose of the High Risk for Suicide PRF [Patient Record Flag] is to communicate to VA staff that a veteran is at high risk for suicide and the presence of a flag should be considered when making treatment decisions."

<sup>10</sup> VHA Directive 2008-036. High risk for suicide flags are required to be reevaluated at least every 90 days and removed when the patient's high risk for suicide status has resolved.

<sup>11</sup> "Therapeutic Risk Management-Risk Stratification Table,' Rocky Mountain Mental Illness Research Education and Clinical Center (MIRECC), [https://www.mirecc.va.gov/visn19/trm/docs/RM\\_MIRECC\\_SuicideRisk\\_Table.pdf](https://www.mirecc.va.gov/visn19/trm/docs/RM_MIRECC_SuicideRisk_Table.pdf), accessed June 3, 2022. Acute risk for suicide indicates a patient may be at risk of attempting suicide within minutes or days while chronic risk for suicide indicates a long-term risk. A patient with high acute risk for suicide typically requires psychiatric hospitalization. A patient with high chronic risk for suicide typically requires routine outpatient mental health care and suicide risk screening as well as a suicide safety plan.

<sup>12</sup> The OIG reviewed EHR documentation related to the deactivation of the high risk for suicide flag and determined that it was appropriate.

to continue care with medical and mental health providers, recommended following the suicide safety plan, and that the suicide prevention team remained available to the patient if needed.<sup>13</sup> At a follow-up visit the next month, the facility psychiatrist documented that the patient was not at acute risk for suicide.

One month later, the patient presented to the facility's Emergency Department at 5:14 a.m. with [chief complaints](#) of [urinary retention](#) and depression. The patient reported not having taken medication for enlarged prostate for several days and also reported body aches, rating the pain "7/10."<sup>14</sup> The patient informed Nurse 1 of being depressed, feeling "dissatisfied with life," and stated, "I don't want to die." The patient also reported "substance abuse of unknown amount." Nurse 1 documented a negative suicide risk screen. The patient's blood pressure was elevated, but other vital signs were normal. The [problem list](#) in the Emergency Department [triage](#) note included cocaine dependence and history of deliberate self-harm.

Nurse 1 assigned the patient an [Emergency Severity Index](#) level 3 and documented at 5:30 a.m. that the completed [bladder scan](#) showed 89 milliliters of urine (a small residual amount) in the bladder.<sup>15</sup> Additionally, Nurse 1 documented that the Emergency Department physician (physician) was "made aware" of the patient at 5:30 a.m. and then documented that the patient was pending evaluation and intervention of the physician at 6:15 a.m. Nurse 1 documented giving report to an incoming Emergency Department nurse at 7:30 a.m.

The patient had not been seen by the physician until the patient was found unresponsive by an Emergency Department technician at 7:37 a.m. [Cardiopulmonary resuscitation](#) was initiated and additional Emergency Department staff responded, including the chief of the Emergency Department and the incoming physician. The incoming Emergency Department nurse documented that the patient "appears to have a [ligature](#) mark to the neck." Emergency Department staff followed [advanced cardiac life support](#) protocol for the patient but resuscitation efforts were unsuccessful. The incoming Emergency Department physician pronounced the patient's death at 7:49 a.m. In a note entered shortly after the patient's death, the chief of the Emergency Department documented that the patient had "evidently formed a ligature" from the exam room's [ophthalmoscope](#) cord. The chief of the Emergency Department documented that

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<sup>13</sup> Between the date of inactivation of the high risk for suicide flag, and the patient's visit to the facility's Emergency Department in early fall 2021, the patient had visits with a facility primary care provider, psychiatrist, and homeless program social worker.

<sup>14</sup> EL Plan et al., "Likert Pain Score Modeling: A Markov Integer Model and an Autoregressive Continuous Model," *Clinical Pharmacology and Therapeutics* 91, (May 2012): 820-828. Pain intensity is assessed on a 0 to 10 point scale, with 0 indicating the absence of pain and 10 representing the most severe pain.

<sup>15</sup> Emergency Nurses Association, *Emergency Severity Index: A Triage Tool for Emergency Department Care*, Version 4, 2020 Edition. A patient assigned a level three triage category is considered to be stable with no acute risk or immediate threat to life. Emergency Department nurses base this categorization on the patient's stability and the number of resources, such as medications, procedures, and laboratory or radiology studies, required to evaluate the patient.

the patient's family was notified of the patient's death. An autopsy determined that the patient died by suicide as a result of hanging.

See [Appendix A](#) for a timeline of the patient's Emergency Department visit.

## Inspection Results

### 1. Deficiencies in Quality of Care

The OIG identified that deficiencies in the quality of Emergency Department care provided to the patient resulted in a delay of care and may have contributed to the patient's death.<sup>16</sup>

Specifically, the OIG found three areas of deficiencies:

- Administration of a suicide risk screen
- Absence of a physician evaluation of the patient
- Failure to monitor the patient

VHA defines quality care as providing the right type of care for a patient's health condition that results in the best possible outcome. This definition includes keeping the patient safe from [harm](#).<sup>17</sup>

#### Administration of a Suicide Risk Screen

The OIG determined that Nurse 1 may not have properly administered a suicide risk screen, which may have impacted the accuracy of results.

In November 2020, VHA implemented a standardized suicide risk identification strategy in all VA health care systems, including a suicide risk screen.<sup>18</sup> The suicide risk screening tool, known as the Columbia-Suicide Severity Rating Scale, is a standardized eight-item questionnaire used to identify patients who are at risk for suicide and require further evaluation. The Joint Commission emphasizes that the wording of the questions in a suicide risk screening tool should not be changed in any way, as even a small change could affect accuracy.<sup>19</sup> The suicide risk screening tool is built into the national VA Emergency Department triage note, within the EHR, and is required to be completed at every emergency department visit. A patient with a positive

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<sup>16</sup> Information contained within the inspection results originates from the facility's administrative investigation, interviews with facility staff, and the patient's EHR. For brevity, attribution is only provided when necessary to identify the specific source of the information.

<sup>17</sup> "Quality of Care," Access and Quality in VA Health Care, accessed May 18, 2022, <https://www.va.gov/QUALITYOFCARE/>.

<sup>18</sup> VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation," November 10, 2020.

<sup>19</sup> The Joint Commission, *R<sup>3</sup> Report*, "National Patient Safety Goal for Suicide Prevention," November 20, 2019.

suicide risk screen in the emergency department requires a more in-depth follow-up risk evaluation to be completed that same day, if possible, or within the next 24 hours once patient safety is established.<sup>20</sup> Additionally, emergency department staff must monitor patients identified at risk for suicide via direct one-to-one observation until the patient is determined to no longer be at risk by either a psychiatrist or an emergency department physician.<sup>21</sup>

**C-SSRS Screen**

1. Over the past month, have you wished you were dead or wished you could go to sleep and not wake up?  
 Yes *Proceed to question #2 regardless of response.*  
 No
2. Over the past month, have you had any actual thoughts of killing yourself?  
 Yes *If 'Yes', proceed to question #3*  
 No *If 'No', proceed to question #7*
3. Over the past month, have you been thinking about how you might do this?  
 Yes *Proceed to question #4 regardless of response.*  
 No
4. Over the past month, have you had these thoughts and had some intention of acting on them?  
 Yes *Proceed to question #5 regardless of response.*  
 No
5. Over the past month, have you started to work out or worked out the details of how to kill yourself?  
 Yes *If 'Yes', proceed to question #6*  
 No *If 'No', proceed to question #7*
6. If yes to Q5, at any time in the past month did you intend to carry out this plan?  
 Yes *Proceed to question #7 regardless of response.*  
 No
7. In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life (for example, collected pills, obtained a gun, gave away valuables, went to the roof but didn't jump)?  
 Yes *If 'Yes', proceed to question #8*  
 No *If 'No', proceed to scoring*
8. If yes to Q7, was this within the past 3 months?  
 Yes *Proceed to scoring*  
 No

**Figure 1.** VHA required suicide risk screen (Columbia-Suicide Severity Rating Scale) questions.

Source: VHA Suicide Risk Identification and Management SharePoint Site.<sup>22</sup>

<sup>20</sup> VHA Assistant Under Secretary for Health for Clinical Services/Chief Medical Officer memo, "Eliminating Veteran Suicide: Suicide Risk Screening and Evaluation Requirements and Implementation," November 10, 2020.

<sup>21</sup> VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016, amended March 7, 2017.

<sup>22</sup> "Risk ID Suicide Risk Identification," VHA Suicide Risk Identification and Management.

According to a facility administrative investigation report, video footage from the morning of the event showed that Nurse 1 triaged the patient in the dedicated triage room.<sup>23</sup> Nurse 1 documented a negative suicide risk screen in the triage note, and that the patient answered “no” to the following questions:

- Over the past month, have you wished you were dead or wished you could go to sleep and not wake up?
- Over the past month, have you had any actual thoughts of killing yourself?
- In your lifetime, have you ever done anything, started to do anything, or prepared to do anything to end your life?

According to the facility administrative investigation report, Nurse 1 asked the patient the suicide risk questions from memory and did not utilize the computer in the triage room for documentation. The time stamp on the triage note shows Nurse 1 initiated the note after the patient was placed in an exam room. The administrative investigation findings identified that Nurse 1 was unable to recall the suicide risk screen questions when asked to do so.

During interviews, the OIG found facility and Emergency Department leaders’ views varied regarding the appropriateness of conducting the suicide risk screen from memory. The chief of the Emergency Department reported that patients prefer speaking with nurses face-to-face instead of nurses behind a computer. The chief of the Emergency Department also shared that most of the nurses “probably” knew the suicide risk screen questions and expressed that performing the suicide risk screen from memory versus reading the questions equated to the same level of care. An Emergency Department nurse leader reported that nursing staff commonly perform the suicide risk screen by memory but was not confident that the questions could be memorized. In an OIG interview, the associate chief nurse of specialty outpatient services (associate chief nurse) opined that for staff to memorize the entire suicide risk screen would not be possible.

The OIG concluded that Nurse 1 may not have administered the suicide risk screen when conducting the screen from memory. The OIG questions whether the patient’s negative suicide risk administered by Nurse 1 was accurate based upon Nurse 1’s inability to recite the suicide risk screen from memory when asked to do so during the administrative investigation interview. However, the OIG was unable to determine whether administering the suicide risk screen as intended would have resulted in a different outcome.

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<sup>23</sup> The OIG team confirmed during the site visit that the triage room was equipped with a computer for electronic charting.

## Absence of a Physician Evaluation of the Patient

The VA Emergency Medicine Improvement initiative, with oversight by the National Program Office of Emergency Medicine, seeks to meet objectives focused on improving patient flow through the emergency department and improving productivity of resources.<sup>24</sup> The initiative utilizes operational data from VHA emergency departments to establish performance metrics in comparison to one another. A patient flow measure used by VHA as part of this initiative is the “[Door to Doc](#)” metric, which defines national performance goals for patient wait time from arrival in an emergency department to being assigned to a provider and evaluated.<sup>25</sup> The national target “Door to Doc” time is less than or equal to 25 minutes.<sup>26</sup>

### *Nurse 1’s Failure to Communicate*

Communication between emergency department nurses and physicians must be clear and concise. Lapses in communication can lead to patient safety concerns and poor clinical outcomes.<sup>27</sup> The OIG determined that Nurse 1 failed to communicate with the physician that the patient was awaiting evaluation, resulting in a delay of care.

After triage, Nurse 1, designated as the patient’s primary nurse, placed the patient in an exam room. According to the EHR, at 5:30 a.m., Nurse 1 documented that the physician was “made aware” and the patient was waiting for evaluation. During an interview with the OIG, Nurse 1 described going to notify the physician, who was resting on a stretcher in an exam room, of the patient’s arrival. Nurse 1 stated the physician responded to the notification with a “nod and an OK” and reported going back to the nurse’s station to continue with other duties. Furthermore, Nurse 1 reported going back to notify the physician “multiple times” after the arrival of the patient. Additionally, in an interview with the OIG, another Emergency Department nurse on shift that night (Nurse 2) reported that Nurse 1 had stated that the physician was made aware of the patient; however, Nurse 2 did not see Nurse 1 notify the physician. An hour after the patient was placed in the exam room, Nurse 2 reported notifying the physician of a new patient arrival.

According to the facility administrative investigation report, video footage did not support Nurse 1 going to the physician’s location to notify the physician of the patient who was awaiting evaluation. The OIG interviewed the chair of the administrative investigation board in an attempt to reconcile the discrepancy between the facility administrative investigation report findings and

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<sup>24</sup> VHA Support Service Center Manual, “Emergency Medicine Management Tool V3 User Manual,” February 5, 2019.

<sup>25</sup> VHA Support Service Center Manual, “Emergency Medicine Management Tool.” *Door to Doc* time is defined as the time in minutes between patient arrival and the assignment of a physician to a patient. The assignment should occur just prior to the provider’s review of a patient’s chart or patient evaluation.

<sup>26</sup> VHA Support Service Center Manual, “Emergency Medicine Management Tool.”

<sup>27</sup> Daniel Abourbih et al., “Communication Between Nurses and Physicians: Strategies to Surviving in the Emergency Department Trenches,” *Emergency Medicine Australasia* 27, (2015): 80-82.

Nurse 1's assertion of notifying the physician of the patient's arrival. The administrative investigation chair confirmed the video footage viewed during the administrative investigation covered the period from the placement of the patient in the exam room by Nurse 1 through the discovery of the patient kneeling unresponsive on the floor.<sup>28</sup>

### *Physician's Delayed Response*

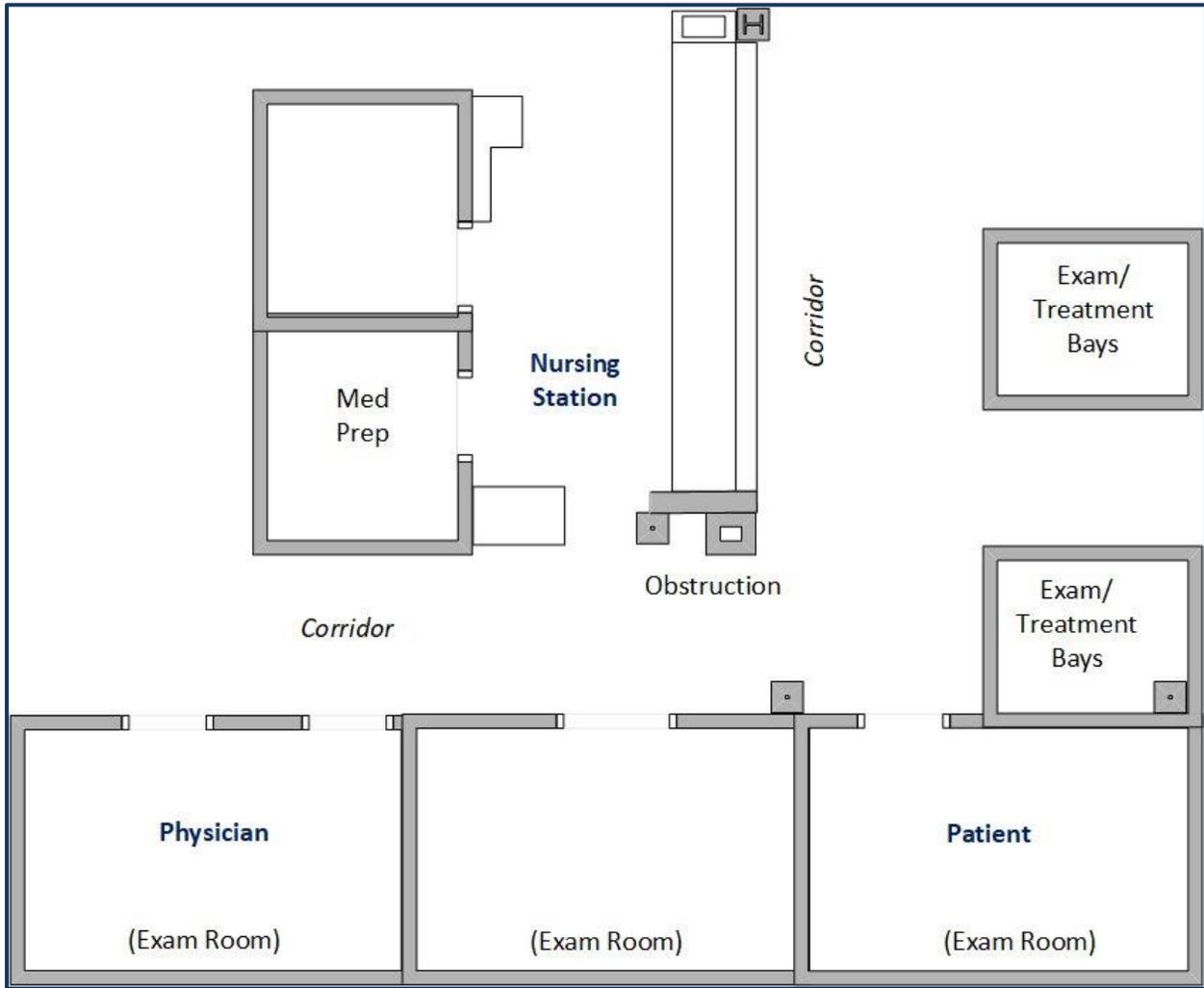
The OIG determined that the patient's care was further delayed as the physician did not evaluate the patient despite having been notified by Nurse 2.

In an OIG interview, the physician described a period in the 14-hour shift prior to the patient's arrival, when all patients in the Emergency Department had been evaluated, including two who were awaiting disposition. At that time, the physician went into an exam room to rest and informed Emergency Department staff of the location (see figure 2) in case any new patients arrived.<sup>29</sup>

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<sup>28</sup> Despite multiple requests, facility staff was unable to provide the OIG with the exact copy of the video footage viewed by the administrative investigation to support the finding. Therefore, the OIG could not independently verify the administrative investigation's conclusion that Nurse 1 did not notify the physician of the patient's arrival. The interview with the administrative investigation chair, however, well supported that the video footage did not support Nurse 1's description of events.

<sup>29</sup> VHA Directive 1101.05(2). VHA policy requires medical facilities to provide a place for Emergency Department physicians to rest while working extended shifts longer than 12 hours. At the time of the inspection, the OIG did not identify any VHA or facility policy that prohibited Emergency Department physicians from resting while on duty.



**Figure 2.** Location of physician, patient, and nursing station in the Emergency Department.  
Source: VA OIG interpretation of the facility’s Emergency Department floorplan.

The physician was still resting in an exam room at the time of the patient’s arrival to the Emergency Department, as well as when Nurse 2 alerted the physician of the patient and another patient awaiting initial physician evaluation. In an OIG interview, the physician recalled Nurse 2’s notification, but acknowledged not immediately acting due to being “slow to move” from the effects of having recently received a vaccine. The OIG learned through the facility’s administrative investigation report and information provided by the chief of the Emergency Department in an interview, that approximately 30 minutes later, at 6:48 a.m., the chief of the Emergency Department arrived for work, found the physician resting in the exam room, and directed the physician to see the patients who were waiting.

At 6:50 a.m., after several day-shift staff members and a social worker assigned to the Emergency Department reported to work, the physician emerged from the room to see patients. The OIG learned through interviews with the physician and the chief of the Emergency Department that the physician first tended to two other patients awaiting disposition because the

social worker and the chief of the Emergency Department were available to provide assistance with placement. The physician reported attempting to evaluate the patient but did not “immediately” see the patient in the exam room and asked an Emergency Department technician to find the patient. The Emergency Department technician went into the exam room and found the patient on the floor in a kneeling position between the supply cart and the wall. The Emergency Department technician identified that the patient was unresponsive, called for help, and began life-sustaining measures at 7:38 a.m. with other Emergency Department staff who had responded to the call.

According to the facility’s administrative investigation report, video footage from the morning of the event showed that over two hours and twenty minutes elapsed from the time the patient arrived in the Emergency Department to the time the patient was found unresponsive<sup>30</sup>

The OIG concluded that Nurse 1’s failure to alert the physician and the physician’s failure to respond to notification by Nurse 2, delayed patient care. The patient was not evaluated by a physician from the time of the Emergency Department admission to the time the patient was found unresponsive. A physician evaluation could have identified a potential change in the clinical and mental health status of the patient and provided timely intervention over the course of the Emergency Department visit. While the patient’s exact time of hanging is unknown, had Nurse 1 notified the physician after placing the patient in an exam room and the physician responded to this notification, the physician may have been able to evaluate the patient before the patient completed suicide, potentially changing the outcome for the patient.

### **Nurse 1’s Failure to Monitor Patient**

The OIG determined that Nurse 1 did not monitor the patient after the initial triage through the duration of the Emergency Department visit, which contributed to the patient’s poor quality of care.

A facility standard operating procedure requires that nursing staff monitor the vital signs of Emergency Department patients who are triaged as an Emergency Severity Index level 3 every two hours.<sup>31</sup> At the time of this inspection, the Emergency Department nurse manager told the OIG that facility policies and standard operating procedures did not include a requirement for Emergency Department nursing staff to perform [hourly rounding](#).<sup>32</sup> Timely and accurate patient

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<sup>30</sup> The OIG reviewed “Door to Doc” data, from October 1, 2019, through September 30, 2020, for the facility and noted that this delay was not consistent with the facility’s average “Door to Doc” time, which was less than the national target.

<sup>31</sup> Facility Standard Operating Procedures 118-40, “Nursing Process and Documentation,” July 31, 2019.

<sup>32</sup> Matthew D. Mitchell et al., “Hourly Rounding to Improve Nursing Responsiveness: A Systematic Review,” *Journal of Nursing Administration* 44, no. 9, (September 2014): 462-472. Although the specific protocols for hourly rounding vary between healthcare facilities, typically both nurses and unlicensed nursing support staff (technicians) can be responsible for conducting hourly rounding.

monitoring by nursing staff in the Emergency Department is important for early identification of changes in clinical status. Inconsistent monitoring by nurses can result in avoidable patient deterioration, incomplete nursing documentation, and poor patient satisfaction.<sup>33</sup> The Institute for Healthcare Improvement endorsed hourly rounding as the best way to increase patient safety, quality of care, and patient satisfaction.<sup>34</sup>

The OIG found that Nurse 1 triaged the patient as an Emergency Severity Index level 3 and placed the patient in the exam room at 5:18 a.m. The OIG learned through the facility's administrative investigation report and in an interview with Nurse 1, that Nurse 1 did not make any further contact with the patient prior to giving end-of-shift report to the incoming Emergency Department nurse at 7:30 a.m. Video footage reviewed in the facility's administrative investigation revealed that the last time Emergency Department staff made contact with the patient while alive was at approximately 5:19 a.m. when Nurse 2 completed the bladder scan.<sup>35</sup> Additionally, the facility's administrative investigation determined that Emergency Department staff did not make any further contact with the patient until the patient was found unresponsive at 7:38 a.m. despite vital signs being due at 7:19 a.m. per facility policy.<sup>36</sup>

During an OIG interview, the Emergency Department nurse manager stated always having a personal expectation to round on patients hourly; however, the expectation was not formally communicated to Emergency Department nursing staff until after this event. The post-event communication of hourly rounding expectations came in the form of an email sent to all Emergency Department nurses and unlicensed nursing support staff and included a documentation requirement.

The OIG concluded that the absence of continued patient monitoring by Nurse 1 reflects a deficiency in the quality of care provided to the patient. This lack of patient monitoring represents an additional missed opportunity to identify a potential change in the clinical and mental health status of the patient and provide timely intervention over the course of the Emergency Department visit.

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<sup>33</sup> K. Curtis, "The Implementation of an Emergency Nursing Framework (HIRAID) Reduces Patient Deterioration: A Multi-Centre Quasi-Experimental Study," *International Emergency Nursing* 56, (May 1, 2021).

<sup>34</sup> Juli F. Daniels, "Purposeful and Timely Nursing Rounds: A Best Practice Implementation Project," *JBIR Database of Systematic Reviews and Implementation Reports* 14, (January 2016): 248-267.

<sup>35</sup> In addition to Nurse 1 and Nurse 2, there was one other nurse on duty. There were no technicians on night shift duty during the patient's Emergency Department visit.

<sup>36</sup> Facility Standard Operating Procedures 118-40.

## 2. Deficiencies in Facility Leaders' Response

The OIG determined that facility leaders took action in response to the patient's death by conducting a root cause analysis (RCA), an administrative investigation, and [peer reviews](#).<sup>37</sup> However, the OIG found

- Deficiencies in the facility's RCA process
- Failure to complete an institutional disclosure
- Failure to file a report with the state licensing boards (SLB)

### Deficiencies in the Root Cause Analysis Process

The OIG determined that facility leaders did not conduct a thorough RCA review of the event by failing to include an Emergency Department subject matter expert as part of the RCA team. Additionally, the RCA team did not interview individuals directly involved with the event or other staff with experience and knowledge of the Emergency Department process. Facility leaders' failure to conduct a thorough RCA review limited the opportunity to improve patient safety and prevent the reoccurrence of the event.

An RCA is a type of confidential quality improvement process used to identify factors that cause or contribute to [adverse events](#).<sup>38</sup> VHA requires an RCA to be completed for any patient death by suicide that occurs while the patient is receiving care and treatment in an area that is fully staffed 24-hours a day.<sup>39</sup> A thorough RCA must identify system vulnerabilities and their potential contribution to the adverse event, and determine whether or not potential process or system improvements would decrease the likelihood of a similar event in the future.<sup>40</sup>

#### *Failure to Include an Emergency Department Provider*

The OIG found that facility leaders failed to include subject matter experts identified in the RCA charter on the RCA team. The RCA team did not include a provider with experience and knowledge of the Emergency Department processes.

For an RCA to be considered credible, VHA requires that RCA teams include participation by individuals that have knowledge of the clinical processes and systems being reviewed.<sup>41</sup>

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<sup>37</sup> The OIG reviewed peer reviews completed on all relevant clinical staff and found no deficiencies in the findings, process, or procedure.

<sup>38</sup> VHA Handbook 1050.01, VHA National Patient Safety Improvement Handbook, March 4, 2011.

<sup>39</sup> VHA Handbook 1050.01. VHA Deputy Under Secretary for Health for Organizational Excellence memorandum, "Annual Minimal Requirements for Facilities to Perform Patient Safety Analyses," March 17, 2020.

<sup>40</sup> VHA Handbook 1050.01.

<sup>41</sup> VHA Handbook 1050.01.

The charter, signed by the Deputy Executive Director, identified seven facility staff members by position title, including an Emergency Department provider, for the RCA team; however, the final RCA report presented to facility leaders did not include an Emergency Department provider as a member of the team. A patient safety manager reported to the OIG that, due to the time frame required, the RCA team moved forward with the review without the identified team member. The acting patient safety manager reported sending an email to the chief of Medicine, deputy chief of staff, and the Chief of Staff on October 14, 2021, to request the name of an Emergency Department physician to fill the position listed in the RCA charter but did not receive a response. The acting patient safety manager reported relaying the lack of response to the director of QSVHR who instructed the team to proceed with the RCA based on guidance from facility leaders. During interviews, the director of QSVHR acknowledged that the RCA charter signed by the Facility Director identified that an Emergency Department provider was needed, but did not provide any further explanation of why an Emergency Department provider was not included on the team.

A member of the RCA team told the OIG that the team raised concerns “multiple times” regarding proceeding without an Emergency Department provider. The RCA team member stated that the failure to include required members negatively impacted the outcome of the RCA and told the OIG,

If you’re going to be looking at the exact process from when the patient entered the door until the patient was found, you need to have all your stakeholders involved. That includes nursing, providers, social work responsibilities, mental health responsibilities, if they would have been notified, how would they have prudently responded. Not having a provider to answer their perspective, really doesn’t allow you to paint the whole picture. Nursing and providers and all of our allied staff work as a team, so trying to investigate an airplane crash but not getting the flight engineer or not getting the copilot.

The OIG concluded that facility leaders failed to ensure the RCA team included identified subject matter experts and therefore, negatively impacted the team’s ability to conduct a sufficient review. Input from identified subject matter experts is critical to fully understanding potential system and process breakdowns that may have contributed to the event.

### ***Failure to Interview Emergency Department Staff***

The OIG learned that the facility’s initiation of an RCA before the completion of an administrative investigation led to an incomplete review by the RCA team in order to avoid what the staff explained as perceived interference with the RCA. As a consequence, the RCA team failed to interview staff directly involved in the patient’s care or other staff who were experienced and knowledgeable in the processes of the Emergency Department.

Unlike RCAs, administrative investigations are not confidential quality improvement documents and are not protected. VHA recommends that if both an administrative investigation and RCA are to be conducted, it is recommended that the administrative investigation be conducted prior to the RCA to prevent confidential information derived from an RCA from being improperly used in the administrative investigation and to avoid the perception that information from the RCA was used improperly.<sup>42</sup> VHA provides guidance for conducting an RCA, including establishing the initial sequence of events using facts and information gathered through interviewing employees.<sup>43</sup> VHA requires that RCA teams interview individuals directly involved with an adverse event as a part of the RCA process.<sup>44</sup>

The Deputy Executive Director chartered the RCA in early fall 2021 to determine the root cause and contributing factors to the patient's death by suicide. The Chief of Staff told the OIG that, due to the nature of the event and possibility for disciplinary action, the decision was made to complete both the RCA and an administrative investigation. The Facility Director officially convened the administrative investigation board in mid-fall 2021, one day prior to the presentation of the final RCA results to facility leaders. In leading the administrative investigation, the administrative investigation board members were tasked to review allegations of inappropriate patient care provided by the Emergency Department physician and Nurse 1.

According to a member of the RCA team and a patient safety manager advising the RCA team, the RCA team did not interview Nurse 1, despite Nurse 1 still working at the facility at the time of the RCA. A patient safety manager noted that the RCA team included a nurse with "longstanding" Emergency Department experience but acknowledged the team did not conduct interviews with any other Emergency Department nurses due to the pending administrative investigation. Additionally, a patient safety manager reported that the RCA team was unable to interview the Emergency Department physician because the physician was no longer employed by the facility.<sup>45</sup> During interviews, an RCA team member reported that the team was "not allowed" to interview staff and instead had to focus the review on the information available in the patient's medical record. The RCA team member explained to the OIG the importance of the team interviewing not just the nurse involved in the care of the patient, but also other nursing staff, describing this as "vital" to obtaining a greater understanding of actions taken during the care of the patient. The RCA team member described uncertainty about whether the administrative investigation addressed questions that remained unanswered by the RCA.

However, the director of QSVHR told the OIG that the RCA team was not given any restrictions while conducting the review and had the same information as the administrative investigation

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<sup>42</sup> VHA Handbook 1050.01.

<sup>43</sup> VA National Center for Patient Safety, "Root Cause Analysis (RCA) Step-By-Step Guide," July 1, 2016.

<sup>44</sup> VHA Handbook 1050.01.

<sup>45</sup> Three days after the RCA was chartered, the Chief of Staff issued a letter terminating the Emergency Department physician's contract with the facility.

board members. An RCA team member told the OIG that additional documentation was provided by the director of QSVHR to support the RCA review.

In an interview with OIG, the director of QSVHR described the challenges faced by the RCA team; noting that the team had a “difficult time” completing the review because team members were viewing issues more from an individual or performance standpoint than a systemic or process issue. The director of QSVHR further explained this difficulty contributed to RCA corrective actions that lacked specificity due to the RCA teams’ attempt to prevent impact on the pending administrative investigation.

The OIG concluded that the RCA team failed to conduct a sufficient review by not interviewing key Emergency Department staff to gain greater insight into department processes. Excluding input from available staff involved in Emergency Department processes decreased the likelihood of identifying root causes and, therefore, limited the utility of the RCA in preventing the same or similar event. Additionally, performing the RCA after the completion of the administrative investigation would have been consistent with VHA policy and would have given the RCA team the ability to glean facts.

## **Failure to Complete an Institutional Disclosure**

The OIG determined that facility leaders did not complete a timely institutional disclosure to the patient’s family related to the patient’s death in the Emergency Department.

An institutional disclosure is a formal process used by facilities to “inform the patient or the patient’s personal representatives that an adverse event has occurred.”<sup>46</sup> Specific information about the patient’s rights and recourse options is also provided. VHA policy states that “when an adverse event has resulted in or is reasonably expected to result in death or serious injury, an institutional disclosure must be performed regardless of when the event is discovered.” Facility leaders are responsible for initiating an institutional disclosure “as soon as reasonably possible” after an event “and generally within 72 hours.”<sup>47</sup> VHA and facility policies identify patient suicide in a healthcare facility as a reportable adverse event that warrants disclosure.<sup>48</sup>

The Chief of Staff told the OIG that an institutional disclosure was not completed at the time of the patient’s death in early fall 2021. The Chief of Staff described the lack of an institutional disclosure immediately after the event as “an oversight” and attributed this to a focus on administrative responses to the event, including the RCA and an administrative investigation. The Chief of Staff explained that a VISN risk management review on April 14, 2022, identified the need for an institutional disclosure. The Chief of Staff informed the OIG on April 21, 2022,

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<sup>46</sup> VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018.

<sup>47</sup> VHA Directive 1004.08.

<sup>48</sup> VHA Handbook 1050.01. Medical Center Memorandum 00-68, *Disclosure of Adverse Events to Patients*, March 22, 2019.

of initiating a discussion with other facility leaders regarding a plan to conduct an institutional disclosure “within the next 7–10 business days.”

In follow-up with the OIG on April 22, 2022, the Chief of Staff reported “we will be reaching out to the family early next week” to conduct the institutional disclosure. Two weeks later, the Chief of Staff spoke to the patient’s next of kin to discuss the institutional disclosure process and offered a follow-up phone call with the patient’s family at their convenience. After not receiving a return phone call, the Chief of Staff contacted the next of kin again approximately two and a half weeks later, to again offer an institutional disclosure. As of early fall 2022, an institutional disclosure with the patient’s family had not been completed and documented in the EHR.<sup>49</sup>

The OIG concluded that facility leaders did not complete an institutional disclosure within VHA’s recommended time frame. The OIG is concerned that facility leaders failed to recognize that the patient’s suicide in the Emergency Department required an institutional disclosure and that six months elapsed before the Chief of Staff attempted to make the disclosure. The failure to provide an institutional disclosure after an event represents a missed opportunity to inform a patient’s family or representatives about all significant facts regarding the event and has the potential to erode the trust that patients and their families have in their healthcare system.

## **Failure to File Report with State Licensing Boards**

The OIG determined that facility leaders did not comply with VHA requirements for reporting Nurse 1 to the SLBs in the three states in which the nurse was actively licensed.<sup>50</sup>

VHA requires facility directors to report to SLBs, any healthcare professional, regardless of employment status, who demonstrates behavior or clinical practice that substantially fails to meet accepted standards and that raises concerns for patients’ safety. This includes reporting to a SLB any healthcare professional who resigned before serious concerns raised about the healthcare professional’s clinical competence were resolved.<sup>51</sup>

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<sup>49</sup> VHA Directive 1004.08. Facility leaders are required to document completion of an institutional disclosure in the patient’s EHR.

<sup>50</sup> VHA Directive 1100.18, *Reporting and Responding to State Licensing Boards*, January 28, 2021. State licensing boards (SLBs) are responsible for authorizing healthcare professionals to provide healthcare services. An SLB may or may not undertake additional formal proceedings against the professional’s license after receiving a report from VHA regarding concerns with a healthcare professional’s clinical practice. Based on the evidence reviewed, the OIG did not find that VHA Handbook 1100.18 required the facility to report the Emergency Department physician, who was a contract employee. The policy requires reporting to SLBs when a provider is removed from a contract following the completion of a disciplinary action; however, the evidence does not support that the facility took any disciplinary action, only that the facility terminated the contract. Further, although the VA has broad authority to report a provider whose behavior or clinical practice raises reasonable concern for the safety of patients, according to the provider’s exit review and the administrative investigation findings, this was not substantiated.

<sup>51</sup> VHA Handbook 1100.18.

VHA policy outlines a five-step SLB reporting process that facility directors must use to determine whether concerns identified upon a healthcare professional's resignation meet the reporting standard.<sup>52</sup> When a healthcare professional leaves a facility, first- or second-line supervisors must indicate on the [Provider Exit Review](#) whether the employee failed to meet generally acceptable standards of care that raised concerns for patient safety. Facility credentialing and privileging program managers must evaluate all Provider Exit Reviews and initiate the SLB reporting process on healthcare professionals identified by their supervisor on the review form as failing to meet the acceptable standard of care. If the initial review indicates the healthcare professional's behavior or clinical practice failed to meet accepted standards and raises concerns for patient safety, the Facility Director (or appropriate designee) is responsible for ensuring a [comprehensive review](#) is completed.<sup>53</sup> The Facility Director has the final authority to determine, based upon a review of the evidence in the SLB reporting file, that a report to the SLB is warranted.<sup>54</sup>

The OIG learned that in early fall 2021, Nurse 1, who was actively licensed in three states, was detailed to a position outside the Emergency Department "pending the results of an investigation into [Nurse 1's] clinical practice." The next month, facility leaders initiated an administrative investigation to review allegations that Nurse 1 demonstrated "potential inadequate to inappropriate ED [Emergency Department] nurse professional and clinical actions, judgments, and/or decisions" in the care of the patient who completed suicide in the Emergency Department in early fall 2021.

Effective early 2022, Nurse 1 resigned from the facility, over one month prior to the completion of the administrative investigation. Although the administrative investigation had not been completed, in late 2021 the associate chief nurse and the Emergency Department nurse manager signed the Provider Exit Review form, which documented the reason for the nurse leaving as "resigned/retired" instead of "resigned while under investigation." Additionally, the associate chief nurse and the Emergency Department nurse manager documented that Nurse 1 met "generally-accepted standards of clinical practice" but noted if asked for a recommendation, that Nurse 1 would need "proctoring/remediation/reorientation." The documentation in the Provider Exit Review form failed to identify that Nurse 1 was the subject of an ongoing administrative investigation at the time of resignation and noted that SLB reporting was not indicated. The administrative investigation was completed in early 2022, and found that Nurse 1 failed to meet the standards of care for the "medical center and State Board." Based on the findings, the

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<sup>52</sup> VHA Handbook 1100.18. The five-step SLB reporting process includes the initial review stage, comprehensive review stage, decision stage, privacy officer review stage, and reporting stage.

<sup>53</sup> VHA Directive 1100.18. Examples of practice concerns that merit a comprehensive review include (but are not limited to): significant deficiencies in clinical practice, patient neglect or abandonment, and falsification of medical records.

<sup>54</sup> VHA Handbook 1100.18.

administrative investigation recommended that “adverse action” be taken against Nurse 1 in accordance with the Title 38 Table of Penalties for the following offenses:<sup>55</sup>

- Endangering the safety of or causing injury to anyone on VA premises
- Intentional falsification, misstatement, or concealment of material fact in connection with employment or any investigation, inquiry, or other proper proceeding
- Carelessness or negligence resulting in waste or delay
- Leaving job, VA premises, or job to which assigned during working hours, without proper permission

During an interview with the OIG, the Emergency Department nurse manager acknowledged being aware of both the administrative investigation and the fact that Nurse 1 had been detailed to a position out of the department pending the investigation, but did not consider that Nurse 1 was under investigation at the time of resignation. The Emergency Department nurse manager’s decision to not include information that Nurse 1 was under investigation on Nurse 1’s Provider Exit Review was based on an understanding that the investigation’s scope was focused on the event itself and not concerns specific to Nurse 1.

The associate chief nurse responsible for oversight of the Emergency Department also reported being aware of the administrative investigation and Nurse 1’s detail during the investigation. Similar to the Emergency Department nurse manager, the associate chief nurse reported being unaware that Nurse 1 was the subject of the administrative investigation and described the scope of the investigation as focused on the event. The associate chief nurse also stated that no disciplinary actions were taken at the time of Nurse 1’s resignation because the administrative investigation was considered to be ongoing. The associate chief nurse further explained that reporting to SLBs can always be initiated after a staff member’s resignation based upon administrative investigation recommendations. At the time of the OIG interview in early spring 2022, the associate chief nurse reported being unaware if any reports related to Nurse 1’s care and treatment of the patient had been made to the relevant SLBs.

In late spring 2022, the OIG followed up with the Associate Director for Patient Care Services (ADPCS) and the Acting ADPCS to clarify the findings of the administrative investigation and recommendations.<sup>56</sup> The Acting ADPCS explained that the ADPCS continued to take responsibility for actions related to the investigation. The Acting ADPCS reported not reviewing

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<sup>55</sup> VA Handbook 5021/15, *Employee/Management Relations*, Part I, Appendix A, “Range of Penalties for Stated Offenses,” July 19, 2013.

<sup>56</sup> In correspondence with the OIG, the facility’s ADPCS reported being detailed from late 2021 through mid-2022 to cover a position at a different VA medical center shortly after this event. At the time of the OIG inspection, an Acting ADPCS was covering the position while the permanent ADPCS was on detail.

the Provider Exit Review at the time of Nurse 1's resignation and acknowledged not reviewing the results of the completed administrative investigation.

The ADPCS reported being aware that Nurse 1 would "likely" be a subject of the administrative investigation at the time it was initiated but had not received or reviewed the original administrative investigation charter or the Provider Exit Review prior to receiving the documents in spring 2022. During correspondence with the OIG, the ADPCS acknowledged considering Nurse 1 to be under investigation at the time of resignation and that information should have been included on the Provider Exit Review form. The ADPCS stated that, at the time of the Provider Exit Review, no action had been taken to determine if reporting Nurse 1 to the relevant SLBs was indicated. The ADPCS described the administrative investigation findings and recommendations as conduct-related and not based on clinical competency.

In early spring 2022, the Acting ADPCS forwarded a memorandum from the Facility Director via email to the ADPCS requesting a written response with action plans for the recommendations outlined in the administrative investigation. In an email to the OIG, the ADPCS discussed the administrative investigation recommendations with a facility human resources representative, and after reviewing VHA Handbook 1100.18, opined that the findings did not meet the threshold for SLB reporting.<sup>57</sup> In mid-spring 2022, the ADPCS submitted a formal response to the Facility Director, which included the conclusion that "no actions" would be taken regarding any potential actions related to Nurse 1's care of the patient. In correspondence with the OIG, the Facility Director acknowledged reviewing Nurse 1's Provider Exit Interview and agreed with the ADPCS's interpretation that the administrative investigation findings were related to Nurse 1's conduct, and not based on clinical competency. Based on the opinion of the ADPCS, the Facility Director decided not to initiate an SLB report. The Facility Director told the OIG that the requirement for initiating an SLB report is triggered when an employee resigns or is removed when serious concerns are raised about an employee's professional clinical competency. However, VHA Handbook 1100.18 states that SLB reports should be initiated in cases where either a professional's "behavior" or "clinical practice" concerns fail to meet accepted standards and raise concerns for patients' safety.<sup>58</sup>

The facility credentialing and privileging supervisor confirmed that no report was made to the relevant SLBs for Nurse 1 as "there was no indication that reporting was required" based on the Provider Exit Review forms received. Additionally, the credentialing and privileging supervisor reported being unaware that Nurse 1 was the subject of an administrative investigation at the time of resignation.

The OIG determined that the ADPCS and the Facility Director failed to comply with VHA policy when determining whether to initiate an SLB report for Nurse 1. The decision to not

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<sup>57</sup> VHA Handbook 1100.18.

<sup>58</sup> VHA Handbook 1100.18.

report was based on their interpretation of the administrative investigation findings that Nurse 1's conduct was of concern but did not have clinical implications despite the conclusion by the administrative investigation that Nurse 1 failed to meet the standard of care. In accordance with VHA policy, which states that failure to meet accepted standards by behavior or clinical practice, the facility is required to initiate reporting to Nurse 1's three SLBs.<sup>59</sup> Further, the OIG concluded that although facility and Emergency Department leaders were aware of the ongoing administrative investigation and clinical practice concerns at the time of Nurse 1's resignation, they failed to document that information on the Provider Exit Review form or otherwise communicate the information to the facility credentialing and privileging supervisor. The failure to include this information prevented the additional comprehensive review required by VHA policy, leaving concerns about Nurse 1's clinical competence unresolved. The failure to comply with VHA policy represented a missed opportunity to ensure that a healthcare professional, who was found to have failed to meet the standard of care and endangered the safety of a patient on VA property, was reported to the relevant licensing boards.

## Conclusion

A review of the patient's death by suicide identified deficiencies in the quality of Emergency Department care that may have contributed to the patient's death. The OIG found that the suicide risk screen may not have been administered properly, the patient was not clinically evaluated by a provider, and the patient was not monitored by nursing staff while in the Emergency Department. These deficiencies represent missed opportunities by Emergency Department staff to identify a potential change in the clinical and mental health status of the patient and provide timely intervention over the course of the Emergency Department visit.

Following the patient's death by suicide, facility leaders completed an RCA, an administrative investigation, and initiated peer reviews. However, the OIG determined that the facility's RCA process included deficiencies that prevented a thorough and credible RCA product. The RCA team did not include an Emergency Department provider as a subject matter expert. Also, the RCA team failed to interview facility Emergency Department staff involved in the patient's care based on their interpretation of VHA policy. In conducting both an administrative investigation and an RCA, the facility failed to conduct the administrative investigation first as recommended by VHA policy, in order to avoid any impediments with confidentiality, and for the purpose of gleaning facts for use in the RCA process. These deficiencies resulted in the lack of analysis of the systems issues.

The facility did not identify the need for an institutional disclosure for over six months after the patient's death. In spring 2022, the Chief of Staff recognized that an institutional disclosure was

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<sup>59</sup> VHA Handbook 1100.18.

warranted. However, the OIG is concerned that it took six months and a VISN risk management review to determine that an institutional disclosure was appropriate.

The facility failed to follow VHA requirements for reporting Nurse 1 to the three SLBs where the nurse was actively licensed. The OIG determined that the Provider Exit Review form for Nurse 1 was inaccurately completed. The associate chief nurse and the Emergency Department nurse manager's failure to include that an administrative investigation was still ongoing resulted in the absence of an additional comprehensive review required by VHA policy. The failure to comply with VHA policy represents a missed opportunity to ensure reporting to state licensing boards for the purpose of identifying healthcare professionals whose conduct or practice raised patient safety concerns.

## **Recommendations 1–6**

1. The VA St. Louis Health Care System Director conducts a fact-finding investigation as necessary to determine whether the chief of the Emergency Department's conduct was inconsistent with VA policy and federal regulations and takes action as appropriate.
2. The VA St. Louis Health Care System Director establishes a standardized process for the administration of the Columbia-Suicide Severity Rating Scale by Emergency Department staff to patients to maintain the integrity of the suicide risk screen.
3. The VA St. Louis Health Care System Director establishes a formal policy outlining expectations for the monitoring of patients by Emergency Department nursing staff after triage.
4. The VA St. Louis Health Care System Director ensures root cause analyses and administrative investigations are conducted efficiently and effectively if chartered for the same event as per Veterans Health Administration policy.
5. The VA St. Louis Health Care System Director ensures that institutional disclosures are completed within the time frame required by the Veterans Health Administration.
6. The VA St. Louis Health Care System Director ensures compliance with the Veterans Health Administration requirement for reporting healthcare professionals to the appropriate state licensing board when indicated.

## Appendix A: Timeline of Care

**Table A.1. Timeline of the Patient’s Emergency Department Visit in Early Fall 2021<sup>60</sup>**

Time	Details
5:14 a.m.	Patient arrived at facility's Emergency Department
5:18 a.m.	Nurse 1 placed patient in Emergency Department exam room
Approximately 5:19 a.m.	Nurse 2 performed bladder scan <i>(Per video footage, this is the last time facility staff entered the patient's room prior to suicide)</i>
5:20 a.m.	Nurse 1 documented triage note in EHR Patient complained of urinary retention/depression Emergency Severity Index Level 3 assigned Suicide risk screen negative
5:30 a.m.	Nurse 1 documented bedside bladder scan was completed, and physician made aware <i>(Per video footage, Nurse 1 did not notify physician that the patient was present)</i>
6:20 a.m.	Nurse 2 notified physician of patients waiting to be seen
6:48 a.m.	Chief of Emergency Department notified physician of patients waiting to be seen
6:50 a.m.	Physician began seeing patients who were awaiting disposition from earlier in the shift before evaluating the patient
7:38 a.m.	Emergency Department technician found patient unresponsive in exam room between wall and supply cart

*Source: The OIG's analysis of the patient's EHR, interviews with facility staff, and facility's administrative investigation documents related to the event.*

<sup>60</sup> Specific times documented in the EHR may be subject to inaccuracies created by time differences, depending on the accuracy of the watch or clock referenced or incorrect estimations of the time an event occurred.

## Appendix B: VISN Director Memorandum

### Department of Veterans Affairs Memorandum

Date: April 14, 2023

From: Director, VA Heartland Network (10N15)

Subj: Healthcare Inspection—Deficiencies in Emergency Department Care for a Patient Who Died by  
Suicide at the John Cochran Division of the VA St. Louis Health Care System in Missouri

To: Director, Office of Healthcare Inspections (54HL04)  
Director, GAO/OIG Accountability Liaison Office (VHA 10BGOAL Action)

Attached is the facility's response to the VA OIG DRAFT REPORT: DEFICIENCIES IN EMERGENCY  
DEPARTMENT CARE FOR A PATIENT WHO DIED BY SUICIDE AT THE JOHN COCHRAN DIVISION  
OF THE VA ST. LOUIS HEALTH CARE SYSTEM IN MISSOURI

I reviewed and concurred with the facility's implementation plan. No additional comments were necessary  
in the technical review of the draft report.

*(Original signed by:)*

Patricia L. Hall PhD., FACHE  
Network Director  
VA Heartland Network (VISN 15)

## Appendix C: Facility Director Memorandum

### Department of Veterans Affairs Memorandum

Date: April 14, 2023

From: Director, VA St. Louis Health Care System (657/00)

Subj: Healthcare Inspection—Deficiencies in Emergency Department Care for a Patient Who Died by  
Suicide at the John Cochran Division of the VA St. Louis Health Care System in Missouri

To: Director, VA Heartland Network (10N15)

1. VA St. Louis Health Care System is dedicated and committed to providing every Veteran in our care with high-quality healthcare services. We are deeply saddened by the passing of this Veteran and our sympathies go out to the Veteran's family and loved ones. There is nothing more important to us at VA than preventing Veteran suicide, and we are utilizing this review to strengthen processes for improved suicide prevention at our facility through the recommendations provided in this report. I have reviewed the draft report and concur with all the Office of Inspector General's (OIG) recommendations.
2. I appreciate the opportunity to improve care provided by the VA St. Louis Health Care System. We will continue working with the OIG, VISN, and VA St. Louis Leadership to implement and sustain corrective actions to prevent similar situations from occurring in the future. I am proud of the healthcare professionals at the VA St. Louis Health Care System for their devotion to our mission and the care they provide to our Veterans. We are committed to ensuring Veterans receive exceptional service and high-quality healthcare at our Medical Center.

*(Original signed by:)*

Candace Ifabiyi, MHA, MSBA, FACHE  
Medical Center Director  
VA St. Louis Health Care System

## Facility Director Response

### Recommendation 1

The VA St. Louis Health Care System Director conducts a fact-finding investigation as necessary to determine whether the chief of the Emergency Department's conduct was inconsistent with VA policy and federal regulations and takes action as appropriate.

Concur.

Target date for completion: August 9, 2023

### Director Comments

The VA St. Louis Health Care System Medical Center Director (MCD) chartered the Fact-Finding Investigation (FFI) on April 17, 2023, which will commence on April 24, 2023, as recommended by the Office of Inspector General. The FFI will be completed by June 16, 2023. After the completion of the FFI, recommendations will be addressed by the Senior Executive Leadership Team and MCD.

### Recommendation 2

The VA St. Louis Health Care System Director establishes a standardized process for the administration of the Columbia-Suicide Severity Rating Scale by Emergency Department staff to patients to maintain the integrity of the suicide risk screen.

Concur.

Target date for completion: October 31, 2023

### Director Comments

The Associate Director of Patient Care Services (ADPCS) has evaluated and determined the reasons for noncompliance. The ADPCS, in conjunction with the Emergency Department (ED) Associate Chief Nurse and ED Nurse Manager have developed a standardized process for the administration of the Columbia-Suicide Severity Rating Scale (CSSR) for every ED patient as a part of the ED staff's Triage clinical practice and Triage documentation. The ED staff sustain and maintain the integrity of suicide risk screens compliance in accordance with the VHA Directive 1101.14, "Emergency Medicine," dated March 20, 2023, and the VA St. Louis Health Care System, Standard Operating Procedure (SOP) 116-23057 "Identifying and Enhancing Care for Patient at Risk for Suicide" dated January 10, 2023.

The ED Nurse Manager retrained 100 percent (28/28) of the VA St. Louis Health Care System, ED Registered Nurses (RN) on the use of the CSSR. The ED Nurse Manager will randomly audit CSSR compliance on a monthly basis to achieve greater than or equal to 90 percent compliance

for six consecutive months. Compliance audits will be reported to the Quality Executive Board on a quarterly basis.

### **Recommendation 3**

The VA St. Louis Health Care System Director establishes a formal policy outlining expectations for the monitoring of patients by Emergency Department nursing staff after triage.

Concur.

Target date for completion: October 31, 2023

### **Director Comments**

The ADPCS has evaluated and determined reasons for noncompliance. In accordance with the VHA Directive 1101.14, "Emergency Medicine," dated March 20, 2023, and the VA St. Louis Health Care System SOP 118-22040, "Nursing Process and Documentation Standards," establishes formal policy outlining the expectations for the monitoring of patients by ED nursing staff after triage for Veterans.

The ED Nurse Manager will randomly audit chart notes for on-going monitoring of patients by ED nursing staff after triage compliance on a monthly basis to achieve greater than or equal to 90 percent compliance for six consecutive months. Compliance audits will be reported to the Quality Executive Board on a quarterly basis.

### **Recommendation 4**

The VA St. Louis Health Care System Director ensures root cause analyses and administrative investigations are conducted efficiently and effectively if chartered for the same event as per Veterans Health Administration policy.

Concur.

Target date for completion: October 31, 2023

### **Director Comments**

On January 29, 2023, the VA St. Louis Health Care System acquired a new MCD. Considerations for improvement with Root Cause Analyses (RCA), Administrative Investigation Boards (AIB), and FFIs was evaluated and considered when developing the action plan. On March 3, 2023, the Office of Quality Management (QM) began monitoring 100 percent compliance with all RCAs, AIBs, and FFIs in relation to all supporting VHA Policies. Real time updates and compliance will be provided to the MCD weekly during established QM Briefings,

or if urgent escalation is considered, daily during Morning Directors Report. The Office of QM will track compliance ongoing until closure of any events.

## **Recommendation 5**

The VA St. Louis Health Care System Director ensures that institutional disclosures are completed within the time frame required by the Veterans Health Administration.

Concur.

Target date for completion: September 30, 2023

### **Director Comments**

On April 14, 2023, the Facility completed the institutional disclosure to the Next of Kin of the Veteran. The Chief of Staff (COS), with collaboration of the Risk Manager has reviewed VA St. Louis Health Care System's institutional disclosure process against VHA Directive 1004.8 "Disclosure of Adverse Events to Patients," Dated October 31, 2018. The COS and Risk Manager will develop and implement a process for tracking all institutional disclosure timelines to ensure timeliness of resolution as outlined by VHA Policy. The COS office will audit compliance with the timeliness of institutional disclosures until a benchmark of 90% are resolved within timeframes outlined in VHA Policy for six consecutive months. The COS will report compliance to the MCD monthly until benchmark goal is achieved.

## **Recommendation 6**

The VA St. Louis Health Care System Director ensures compliance with the Veterans Health Administration requirement for reporting healthcare professionals to the appropriate state licensing board when indicated.

Concur.

Target date for completion: September 30, 2023

### **Director Comments**

The COS and ADPCS, in partnership with the Credentialing and Privileging Office, has evaluated and determined reasons for noncompliance. COS, ADPCS, and the Credentialing and Privileging Office will develop and implement a process for monitoring licensed healthcare professionals for noncompliance of practice as outlined in VHA Directive 1100.18, Reporting and Responding to State Licensing Boards (January 28, 2021). The Credentialing and Privileging Office, under direction of the COS and ADPCS offices, will track all healthcare professionals that require reporting to a state licensing board when indicated. The Credentialing and Privileging Office will continue to monitor and audit until a benchmark of 90% compliance is met for six consecutive months. The Credentialing and Privileging Office will report compliance

to the MCD, COS, and ADPCS monthly on the status of reporting of healthcare professionals when indicated.

## Glossary

*To go back, press “alt” and “left arrow” keys.*

**administrative investigation.** An investigative process where evidence and facts are gathered about an event, usually conducted to improve administrative effectiveness and efficiency. Facility directors may utilize the results of an administrative investigation when determining what type of administrative action, including disciplinary action, may be taken against an employee. In some cases, an administrative investigation and an RCA may be appropriate to conduct for a specific event.<sup>1</sup>

**advanced cardiac life support.** A component of cardiopulmonary resuscitation during which standard protocols are followed to control abnormal heart rhythms, with defibrillation and intravenous medication, and provide airway support, such as by intubation.<sup>2</sup>

**adverse event.** An untoward incident directly associated with a patient’s care or provided under the jurisdiction of a facility. Examples of adverse events include patient falls, complications or errors from a procedure, and missing patients.<sup>3</sup>

**bladder scan.** A bladder scan is an ultrasound procedure that evaluates the amount of urine in the bladder.<sup>4</sup>

**cardiopulmonary resuscitation.** An “organized sequential response to cardiac arrest, including recognition of absent breathing and circulation, basic life support with chest compressions and rescue breathing, advanced cardiac life support (ACLS) with definitive airway and rhythm control” using defibrillation and medications, and post-resuscitative care.<sup>5</sup>

**chief complaint.** A chief complaint is a statement that describes the reason for the patient’s visit, stated in the patient’s own words.<sup>6</sup>

**comprehensive review.** Conducted when the initial review suggests that there is substantial evidence a healthcare professional’s behavior or clinical practice did not meet the standard of care.<sup>7</sup>

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<sup>1</sup> VHA Handbook 0700, *Administrative Investigation Boards and Factfindings*, August 17, 2021.

<sup>2</sup> Merck Manual, “Cardiopulmonary Resuscitation (CPR) in Adults”, accessed January 25, 2023, <https://www.merckmanuals.com/professional/critical-care-medicine/cardiac-arrest-and-cpr/cardiopulmonary-resuscitation-cpr-in-adults?query=cpr#v925728>.

<sup>3</sup> VHA Handbook 1050.01.

<sup>4</sup> Urology Care Foundation, “Ultrasound Imaging,” accessed May 10, 2022, <https://www.urologyhealth.org/urology-a-z/u/ultrasound-imaging>.

<sup>5</sup> Merck Manual, “Cardiopulmonary Resuscitation (CPR) in Adults definition.”

<sup>6</sup> CMS, “Evaluation and Management Services Guide,” accessed May 11, 2022, <https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf>.

<sup>7</sup> VHA Directive 1100.18.

**“Door to Doc” Time.** “Median time in minutes between patient arrival (Time In) and the first assignment of a Provider for all Emergency Department/UCC [urgent care center] patients seen during the time period specified. The first assignment of a Provider should occur immediately prior to a provider’s review of the patient chart and/or seeing the patient.”<sup>8</sup>

**emergency department.** An acute care medical unit that provides resuscitative therapy and stabilization for patients in life-threatening situations. Emergency Departments operate 24 hours a day, seven days a week in a clearly defined area staffed to provide evaluation, treatment, and disposition for a wide range of medical and mental health diagnoses with varying levels of severity.<sup>9</sup>

**emergency severity index.** An algorithm that was developed as a tool for emergency department triage. The algorithm categorizes emergency department patients by acuity and resource needs into five groups, from level 1 (most urgent) to level 5 (least urgent).<sup>10</sup>

**enlarged prostate.** “An enlarged prostate can cause uncomfortable urinary symptoms, such as blocking the flow of urine out of the bladder. It can also cause bladder, urinary tract, or kidney problems.”<sup>11</sup>

**harm.** An injury attributed to the medical management of the patient that extends the length of hospitalization or created a disability at the time of discharge and is not related to the patient’s underlying disease process.<sup>12</sup>

**hourly rounding.** A standardized method used by nursing staff that involves checking on the patient at defined intervals (usually every one or two hours) to efficiently meet patient needs and to ensure patient safety.<sup>13</sup>

**ligature.** Something that is used to bind.<sup>14</sup>

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<sup>8</sup> VHA Support Service Center Manual, “Emergency Medicine Management Tool V3 User Manual,” February 5, 2019.

<sup>9</sup> VHA Directive 1101.05(2).

<sup>10</sup> Emergency Nurses Association, Emergency Severity Index: A Triage Tool for Emergency Department Care, Version 4, 2020 Edition.

<sup>11</sup> “Benign Prostatic Hyperplasia,” Mayo Clinic, accessed June 3, 2022, <https://www.mayoclinic.org/diseases-conditions/benign-prostatic-hyperplasia/symptoms-causes/syc-20370087?p=1>.

<sup>12</sup> “Adverse Events, Near Misses, and Errors,” Agency for Healthcare Research and Quality, accessed May 17, 2022, <https://psnet.ahrq.gov/primer/adverse-events-near-misses-and-errors>.

<sup>13</sup> Juli F. Daniels, “Purposeful and Timely Nursing Rounds: A Best Practice Implementation Project,” *JBI Database System Reviews and Implementation Reports* 14, (January 2016):248-67.

<sup>14</sup> *Merriam-Webster.com Dictionary*, “ligature,” accessed May 31, 2022, <https://www.merriam-webster.com/dictionary/ligature>.

**ophthalmoscope.** An ophthalmoscope is “an instrument for use in viewing the interior of the eye and especially the retina.”<sup>15</sup>

**peer review.** A critical review to determine whether the clinical decisions and actions of a clinician during a specific clinical encounter met the standard of care. VHA requires the initiation of the peer review process when specific concerns about a healthcare professional’s quality or appropriateness of care are identified, or when patients experience negative or unexpected outcomes. Peer reviews are required for all patient deaths by suicide.<sup>16</sup>

**posttraumatic stress disorder.** A mental health condition that is “triggered by a terrifying event – either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares, and severe anxiety, as well as uncontrollable thoughts about the event.”<sup>17</sup>

**problem list.** A problem list is a list of current, active, and past medical diagnoses that may be relevant in the care of a patient.<sup>18</sup>

**Provider Exit Review.** A review conducted by an employee’s first or second-line supervisor within seven days of leaving a facility. An Exit Review is designed to confirm whether a healthcare professional’s clinical practice has met the standard of care while working at the facility. A supervisor must initiate the process for reporting to the appropriate state licensing board if it is determined that the healthcare professional failed to meet the standard of care.<sup>19</sup>

**spinal stenosis.** Spinal stenosis is the narrowing of the space in the spine, which can cause symptoms such as pain, numbness, and muscle weakness. Surgery may be indicated in severe cases of spinal stenosis.<sup>20</sup>

**suicidal ideation.** “Suicidal ideation are thoughts of engaging in suicide-related behavior.”<sup>21</sup>

**triage.** A term used to describe the methodology used by emergency department staff to “assess patients’ severity of injury or illness within a short time after their arrival, assign priorities, and transfer each patient to the appropriate place for treatment.”<sup>22</sup>

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<sup>15</sup> Merriam-Webster.com Dictionary, “ophthalmoscope,” accessed May 11, 2022, <https://www.merriam-webster.com/dictionary/ophthalmoscope>.

<sup>16</sup> VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018.

<sup>17</sup> Mayo Clinic, “Post-traumatic stress disorder,” accessed January 25, 2023, <https://www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967>.

<sup>18</sup> CMS, “EHR Incentive Program,” accessed May 9, 2022, [https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/3\\_maintain\\_problem\\_listep.pdf](https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/3_maintain_problem_listep.pdf).

<sup>19</sup> VHA Directive 1108.18.

<sup>20</sup> Mayo Clinic, “Spinal stenosis,” accessed May 11, 2022, <https://www.mayoclinic.org/diseases-conditions/spinal-stenosis/symptoms-causes/syc-20352961>.

<sup>21</sup> VHA Directive 1160.07, *Suicide Prevention Program*, May 24, 2021.

<sup>22</sup> Michael Christ, et al., “Modern Triage in the Emergency Department,” *Deutsches Arzteblatt International* 107, (2010): 892-898.

**urinary retention.** The inability to empty all the urine from the bladder sometimes caused by conditions such as an enlarged prostate.<sup>23</sup>

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<sup>23</sup> “Definition and Facts of Urinary Retention,” National Institute of Diabetes and Digestive and Kidney Diseases, accessed May 10, 2022, <https://www.niddk.nih.gov/health-information/urologic-diseases/urinary-retention/definition-facts>.

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    Missouri: Mark Alford, Eric Burlison, Cori Bush, Emanuel Cleaver, Sam Graves,  
    Blaine Luetkemeyer, Jason Smith, Ann Wagner

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