Department of Veterans Affairs
Office of Inspector General

Healthcare Inspection

Mismanagement of Inpatient Mental Health Care Atlanta VA Medical Center Decatur, Georgia

Report No. 12-03869-179

April 17, 2013

VA Office of Inspector General
Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations:
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Executive Summary

The VA Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the merit of allegations that negligence and mismanagement by Mental Health Service Line (MHSL) leadership contributed to the death of a mental health (MH) unit inpatient at the Atlanta VA Medical Center (facility). The confidential complainant alleged that this inpatient's death was due to failure of MHSL leaders to:

- Establish effective unit policies
- Ensure monitoring of unit inpatients
- Staff the unit appropriately
- Care about patients

We substantiated that facility and MHSL policies did not sufficiently address patient care safety. We found that the facility did not have adequate policies or practices for contraband, visitation, urine drug screening, or provider notification of clinical changes in a patient's condition. We substantiated that there was failure to monitor patients adequately. We found that the MHSL procedures for monitoring and escorting patients were not sufficient to fully ensure patient safety. We have concerns about the document review and timeliness of follow-up actions for Root Cause Analysis (RCA) recommendations.

We did not substantiate that staffing on the unit was inadequate or that psychiatrists and social workers had inappropriate assignments. We did not substantiate that MHSL leadership does not care about patients. We found inadequate program oversight including a lack of follow-up actions by leadership in response to patient incidents.

We recommended that the Under Secretary for Health ensure that VHA develops national policies that address contraband, visitation, urine drug screens, and escort services for inpatient MH units. We also made seven recommendations to the Veterans Integrated Service Network and Facility Directors to ensure that the facility:

- Inpatient MH unit develops and implements policies that adequately address contraband, visitation, urine drug screening, and escort service.
- Inpatient MH unit employs safeguards for documentation that accurately reflect staff observation of patients.
- Inpatient MH unit strengthens program oversight including follow-up actions taken by leadership in response to patient incidents.
- Strengthens and improves the RCA process to ensure that all information and documentation related to the event are reviewed and that follow up actions are completed and timely.

- Improves communication with staff regarding debriefings and planned actions to address identified deficiencies.
- Inpatient MH units are equipped with functional and well-maintained life support equipment.
- Evaluates the care of the subject patient with Regional Counsel for possible disclosure(s) to the appropriate surviving family member(s) of the patient.

The Under Secretary for Health and the Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. We will follow up on the planned actions until they are completed.

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

TO: Under Secretary for Health (10)

SUBJECT: Healthcare Inspection – Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Decatur, Georgia

Purpose

The Department of Veterans Affairs (VA) Office of Inspector General (OIG) Office of Healthcare Inspections (OHI) conducted an inspection to assess the merit of allegations regarding Atlanta VA Medical Center (facility). The complainant alleged that negligence and mismanagement by the facility's Mental Health Service Line (MHSL) leadership contributed to the death of a subject patient while on the facility's inpatient mental health (MH) unit (the unit).

Background

Facility

The facility is a 405-bed teaching hospital that provides a broad range of emergency, medical, surgical, long-term care, and MH services. The facility is part of Veterans Integrated Service Network (VISN) 7 and serves a veteran population of 87,416 unique patients. The facility also provides outpatient services at eight Community Based Outpatient Clinics located in Austell, Blairsville, East Point, Lawrenceville, Newnan, Oakwood, Rome, and Stockbridge, GA.

The MHSL provides general outpatient and specialized outpatient programs, including trauma and substance abuse (SA) treatment. Overall, unique MH outpatients increased by an estimated 11 percent from fiscal year (FY) 2012 to FY 2013.

The facility has one 40-bed acute inpatient MH unit that is locked and admits only voluntary patients. During FY 2012, the unit's average daily census was 34 with an occupancy rate of 84 percent and an 11-day average length of stay.[1] The unit's leadership consists of the unit Medical Director, Nurse Manager, and Social Work Supervisor. The unit Medical Director reports directly to the Chief, MHSL, who in turn reports to the facility Chief of Staff. The Nurse Manager reports directly to the Associate

[1] Veterans Health Administration Support Service Center's Bed Report.

Nurse Executive, Nursing Home Care Unit/MH. The unit's lead Social Worker reports to the unit Medical Director.

Root Cause Analysis (RCA)

Since 1997, The Joint Commission (JC) has mandated that facilities conduct RCAs to analyze sentinel events,[2] defined as "unexpected occurrences involving death or serious physical or psychological injury, or the risk thereof."[3] Intended to identify underlying factors that contribute or cause variations in performance, RCAs should focus on systems and processes versus individuals.

VA's National Center for Patient Safety (NCPS), established in 1999, developed a standardized method for conducting RCAs of adverse events. The patient safety manager is responsible for organizing an interdisciplinary facility team to conduct the RCA and determine actions that must be taken to try to prevent the occurrence or recurrence of similar events[4] NCPS has a centralized RCA reporting system called "WebSPOT," a software application in the VHA Patient Safety Information System.[5]

Evidence-based research and the unique needs of veterans prompted VHA to tighten environmental design requirements to align with MH safe-design guidelines issued by JC,[6] National Association of Psychiatric Health Systems,[7] and VA.[8] In addition to the elimination and mitigation of environmental conditions that could pose safety risks to patients, MH practices focus on clinical assessment, ongoing evaluation, and individualized treatment of patients.

In June 2011, NCPS reviewed 35 RCAs related to unexpected deaths of inpatients on VHA MH units and identified the following system-wide vulnerabilities[9]:

- Absence of an interdisciplinary approach or appropriate staffing guidelines
- Lack of a standardized approach for patient observation or monitoring
- Delayed response to code or emergent situation

[2] Sentinel events, according to JC include reference to "adverse events."
[3] http://www.jointcommission.org/sentinel_event.aspx
[4] http://www.va.gov/HEALTH/docs/2012_VHA_Facility_Quality_and_Safety_Report_FINAL508.pdf, *2012 VHA Quality and Safety Report*, accessed 12/5/2012.
[5] http://vaww.ncps.med.va.gov/Publications/Frontlines/FrontLines34.html, *Tort liability exposure in the VA: Using Root Cause Analysis (RCA) Team Actions to Minimize Future Tort Event*, accessed 12/5/2012.
[6] JC, "Accreditation Process Guide for Hospitals," Oakbrook Terrace, IL, 2009, p. 63.
[7] National Association of Psychiatric Health Systems, "Design Guide for the Built Environment of Behavioral Health Facilities," ed. 3.0, Spring 2009, updated August 11, 2009, accessed February 19, 2013.
[8] VA Office of Construction and Facilities Management, Mental Health Facilities Design Guide, www.cfm.va.gov/til/dGuide/dgMH.pdf, December 1, 2010, accessed February 19, 2013.
[9] RCA Topic Summaries, National Center for Patient Safety, June 2011 http://vaww.ncps.med.va.gov/Initiatives/RCATopics/index.asp, accessed February 19, 2013.

NCPS recommended VHA:

- Facilitate appropriate management of patient care by implementing interdisciplinary team rounds, including pharmacy and medicine, and a standardized process to ensure timely and accurate consults and transfer of care.
- Standardize observation and monitoring processes and definitions. Develop cognitive aids to reduce reliance on memory and modify observation and monitoring templates to enhance documentation.
- Standardize Rapid Response Systems across all units to include guidance on who to call, and when. Manage and maintain life support equipment. Keep basic skills up to date and know where [and how] to access experts.

VHA MH Guidance

VHA's guidance for the acute treatment of MH patients, the Inpatient MH Services Handbook draft, "describes in more detail the inpatient mental health care and services that are required to be made available without delay to all eligible Veterans who require this level of care."[10] This handbook remains unpublished.

Allegations

The complainant alleged that a MH unit inpatient died due to failure of MHSL leaders to:

- Establish effective unit policies
- Ensure monitoring of unit inpatients
- Staff the unit appropriately
- Care about patients

Scope and Methodology

We conducted site visits from September 26–27, 2012, and February 26–28, 2013. OHI inspectors interviewed facility managers, unit staff, and other key personnel knowledgeable of the issues alleged. We reviewed selected electronic health records (EHRs), facility policies (including memoranda and standard operating procedures), and an RCA on the subject case. We reviewed reports including autopsy, patient incident, patient advocacy, police, staffing, and a 2010 administrative investigative board report.

[10] VHA Handbook Draft, Inpatient Mental Health Services, dated 7/3/2012.

We also reviewed issue briefs, peer review, Press Ganey customer service results,[11] MHSL meeting minutes, employee training records, and performance monitors.

We conducted the inspection in accordance with the *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Case Summary

The subject patient was a male in his twenties with a diagnostic history of alcohol and benzodiazepine[12] abuse, low back pain, and major depressive, borderline personality, eating, and attention deficit hyperactivity disorders. The patient presented to the facility's emergency department with suicidal ideation, underwent one-to-one (1:1) observation and evaluation, and agreed to voluntary admission to the unit. His admission toxicology report was positive for cocaine use. Upon admission, and during the first 3 days, the unit staff observed the patient every 15 minutes. The day after admission, the psychiatrist documented that the patient did not have suicidal ideation and during the course of the week, the patient participated in unit activities, such as group therapy and socialization with other patients, and intermittently complained about inadequate pain management. Because of the patient's improvement, staff changed their observation of him to every 30 minutes on hospital day (HD) 3. On HD 7, the psychiatrist noted that the patient was requesting benzodiazepines and appeared "agitated" when his requests were denied. On HD 8, a nurse charted that the patient had been "perseverating about the eye clinic, and PM&R [Physical Medicine and Rehabilitation]" and that "He was redirected 2x [times] not to go in the room of another patient to talk, but to use common areas instead."

That same day, the patient was scheduled for a 3:00 p.m. ophthalmology appointment to address his complaint of eye irritation. An escort came to the unit, walked with the patient to the first floor Ophthalmology[13] Clinic, and left the patient to wait independently in the waiting room. When Ophthalmology Clinic staff came to the waiting room and initially called the patient's name, they found he was not there. Eventually, he returned to the clinic and clinic staff evaluated his eye condition. Unit staff learned from another patient's escort that the subject patient had been absent from the clinic's waiting room for a time. Therefore, a unit nurse went to the Ophthalmology Clinic around 5:00 p.m. and escorted the subject patient back to the unit. Once on the

[11] Press Ganey is a national consulting company that provides surveys and other management services to health care organizations.
[12] Benzodiazepines are a class of drugs known as tranquilizers. Although invaluable in the treatment of anxiety disorders, they have some potential for abuse and may cause dependence or addiction. Intentional abusers of benzodiazepines usually have other substance abuse problems. http://www.ncbi.nlm.nih.gov/pubmed/15762817, accessed December 3, 2012.
[13] Ophthalmology is the medical specialty that deals with the structure, functions, and diseases of the eye.

unit, the nurse searched the patient for contraband and documented finding only a booklet of matches.

At 6:00 p.m., a unit nurse documented that the patient was alert and ambulating on the unit; however, 30 minutes later, the nurse noticed he was drowsy. The patient attributed the drowsiness to eye dilation, denied drug use, and provided a urine sample for drug testing upon request. The urine toxicology report came back at 7:30 p.m. and was negative. Following the patient's death, another patient reported that he had provided the urine for the urine drug screen (UDS).

Staff documented subsequent checks every 30 minutes using a special observation flow sheet. At 5:35 a.m. on HD 9, a technician attempted to take routine vital signs and found the patient unresponsive. Staff initiated cardiopulmonary resuscitation but were unsuccessful and pronounced the patient dead at 5:57 a.m. An autopsy was performed and indicated that the patient died of opiate[14] or alprazolam[15] poisoning. These medications were not prescribed to him while on the unit. Following the patient's death, a second patient reported to a unit staff member that he and the subject patient shared lorazepam[16] and alprazolam, both of which visitors brought in, on the day of the subject patient's death.

[14] An opiate is a drug (such as morphine or codeine) containing or derived from opium intended to medically induce sleep, alleviate pain, and treat certain gastrointestinal disorders.
[15] Alprazolam is a benzodiazepine sedative that causes dose-related depression of the central nervous system and is useful in treating anxiety, panic attacks, insomnia, and muscle spasms.
[16] Lorazepam is a medication used to relieve anxiety.

Inspection Results

Issue 1: Inpatient MH Unit Policies and Procedures

We substantiated that the facility and MHSL policies did not sufficiently address patient care safety on the inpatient MH unit.

In recent years, MH patient care practices and inpatient environmental standards have evolved significantly in response to suicide and other risk factors encountered in both outpatient and inpatient MH settings. Highlighting the importance of this issue, JC established the 2012 National Patient Safety Goal for behavioral health care to "address the immediate safety needs and most appropriate setting for the treatment of the individual served."[17]

JC requires that facilities have sufficient policies and procedures to ensure safe patient care. At the time of our site visit, the facility did not have any written policies for UDS or unit visitation.

Although policies for contraband and escort service were available, we found that they did not fully address the unique needs of the unit's patients. Further, some unit staff members were not aware of the established policies, practice standards, or how to access the information needed resulting in varying practices.

SA is a co-morbid diagnosis for many MH patients admitted to VHA inpatient MH units.[18] Therefore, the policies and practices needed for locked MH units must also be inclusive of those needed for treatment of SA, such as observed UDS and thorough contraband searches. VHA recognizes the importance of SA monitoring for patients (residents) in the less restrictive MH RRTP, a program historically known as the domiciliary program. MH RRTP residents are to be randomly tested upon return from passes." The requirements for UDS include "observed sample collection in space specifically designed for this purpose or with other methods (e.g., temperature strips) to ensure that samples are not adulterated results."[19] Specific examples of adverse events related to inadequate policies follow:

UDS. The validity of UDS results is dependent on specimen integrity. Donors who know their urine will be "dirty" (positive for drugs), might attempt to alter the specimen to be tested through dilution or substitution with a "clean" urine specimen (from another person). As such, collection conditions that ensure the donor does not tamper with the

[17] The Joint Commission Behavioral Health Care Accreditation Program, *National Patient Safety Goals Effective January 1, 2012*, http://www.jointcommission.org/assets/1/6/NPSG_Chapter_Jan2012_BHC.pdf, accessed December 27, 2012.
[18] The RAND Corporation, *Veterans Health Administration Mental Health Program Evaluation*, 2011, http://www.rand.org/pubs/technical_reports/TR956.html, accessed November 15, 2012.
[19] VHA Handbook 1162.02 MH RRTP.pdf, December 22, 2010

specimen are critical for effective patient care. Staff observation of urine collection is most likely to ensure an accurate sample. Non-witnessed collections can be effective if safeguards, such as searching the donor and collection site, are in place to prevent alteration of the specimen.[20]

The facility had not provided staff with a UDS policy or training prior to the subject patient's death. As such, unit staff did not safeguard a bathroom or observe patients during UDS specimen collection, and abuses, such as specimen switching could occur. As a result, staff used varying methods for obtaining UDS, including having patients provide a specimen cup without monitoring the bathroom, specimen temperature, or time until return.

The day after the subject patient's death, another inpatient confessed to staff that he provided the patient with a urine sample, after the subject patient asked him for a clean urine specimen for his "probation officer."

The facility implemented supervised UDS collection after this event. Interim changes for observed UDS collection were communicated verbally during interdisciplinary staff meetings in July as well as follow-up e-mails to staff. However, there was a 1-2 month delay in training for staff on the UDS policy.

Visitation. Prior to the patient's death, the unit had no written MHSL policies addressing patient visitation, and staff did not observe all visitation. Local practice held that staff would ask visitors to sign in on a log, limit items brought onto the unit and limit visitors' presence to a large group room. However, staff reported inconsistent adherence to these practices.

The facility provided a copy of a new policy, *Unit Visitation Procedure,* dated July 14, 2012; however, the unit Medical Director and Nurse Manager did not sign the document until October 23. Interim changes to the visitation policy were communicated verbally in the July interdisciplinary staff meetings and in follow-up e-mails to all unit staff. As of October, nursing staff had received training on the new visitation policy and other unit staff received a copy of the policy. Consistent with this policy, unit nurses changed their practice to require that visitors be limited in number, sign-in on the unit log, and remain in smaller group rooms under staff observation. The facility installed lockers for visitors to store items prior to entering the unit. To address the immediate need, staff designated two existing lockers on the unit to secure visitor items with the plan to explore purchasing additional lockers for outside the unit. The additional lockers were not yet installed at the time of our site visits. Leadership reported that there was confusion regarding which service was responsible for purchasing the lockers. During our second

[20] Psychiatric Services psychiatryonline.org, *Ensuring Validity in Urine Drug Testing*, February 2008, http://ps.psychiatryonline.org/data/Journals/PSS/3837/08ps140.pdf, accessed December 20, 2012.

site visit when following up on this issue, MH leadership reported that they would order lockers using their fund control point that week.

Contraband. The facility had a 2008 policy entitled "*Protocol for the Control of Contraband for Mental Health Patients,"* which outlined limited actions for admission searches and education of patients and visitors. This policy did not define the search requirements for patients, visitors, and staff, respectively. In addition, it did not address the content for education of visitors or the unique needs and situations common to an inpatient MH unit. Furthermore, facility leaders had not updated the policy, which had a review date of February 2011.

Some staff reported that contraband and rumors of illicit drug use by the unit's inpatients were longstanding on the unit. In addition to the subject patient's death, the following is another example:

- In 2012, a staff nurse discovered 24 pills concealed in the pajama pocket of a MH inpatient who had fallen. The patient claimed he had the pills since his admission (3 days earlier). The nurse documented that the patient's room was searched and that the provider was informed. Although this patient had a history of suicidal behaviors, including a methadone overdose a month prior, staff did not document the type of pills in this case, clinically follow up with the patient, or take action other than to file a patient incident report; no steps were taken to otherwise review and prevent such an event from reoccurring. There was no indication that the provider was aware of the incident, as evidenced by a lack of documented assessment or intervention.

Issue 2: Failure to Monitor Patients

We substantiated that staff's failure to "watch" patients may have contributed to the subject patient's death.

JC requires that health care facilities have written criteria describing early warning signs of a change or deterioration in a patient's condition and that staff monitor patients for changes in clinical condition.[21] We found that there was no standard practice, guideline, or training for unit staff to notify providers of changes in patient conditions. Without notification, providers may be deprived of opportunities to reassess patients and make appropriate changes to medications, observation levels, or other interventions in patient care.

Patient Observation. Nursing/Patient Care Services policy outlines MH staff responsibilities for routine to intensive observation. We found that many unit staff

[21] E-edition.jcrinc.com, Hospital PC.02.01.19, https://e-dition.jcrinc.com/MainContent.aspx, accessed 12/17/2012.

members were either not aware of the policy's existence, or certain of its content. In particular, staff was uncertain about the protocol for making a change to a more intensive observation level when providers were not immediately available to write a change order.

In the case of the subject patient, a unit nurse noticed that he appeared "altered" after returning from his appointment, and reported text paging the psychiatrist on duty (POD) and informing incoming evening staff. The POD reported that she did not receive the page so did not call or visit the unit that evening. There were inconsistencies in the recollection of staff regarding the patient's condition and hand-off communication between shifts, and there is no documentation that staff attempted to contact the POD that evening.

As shown in table 1 below, unit staff refer to specific patient observation levels (POLs) of 1–4, with 4 being the highest level of supervision and fewest privileges. POL ranges from one staff to one patient (1:1) observation to checks every 60 minutes. These are explained in the 12–page pamphlet entitled, *Inpatient Stabilization Unit Guidelines/Expectations*, given to newly admitted patients, but are not defined in any facility policy.

Table 1. Overview of Facility Patient Observation Levels

Level	Observation (on unit)	Supervision (off unit)	Privileges (off unit)
1	60 minute checks	Escorted by MH unit staff or escort services	Patient can be left unmonitored
2	30 minute checks	Escorted by MH unit staff or escort services	Patient can be left unmonitored
3 and 4	15 minute checks or 1:1 observation	Escorted by MH unit staff	MH unit staff must remain with patient

For every patient, regardless of POL, unit staff are required to document their observations using paper flow sheets, which are later scanned into the EHR. We found discrepancies in staff documentation regarding patient observations that raised questions regarding credibility of the information entered. For example, on the day the subject patient was off the unit at his ophthalmology appointment from 3:00–5:00 p.m., the observation flow sheet shows him to be on the unit, checked every 30 minutes, and that unit staff offered him an evening meal at 4:30 p.m.

Following the subject patient's death, nursing leadership implemented three initiatives to improve observation flow sheet accuracy. First, in early August, they attached a photo of each inpatient to the flow sheets after determining that staff did not always know the patients by sight, especially upon returning from time off and observing new admissions.

Second, they began random quality checks of the unit's observation flow sheets in January 2013, and they took appropriate performance-related actions, when necessary. Third, they conducted a time study to identify opportunities to improve multi-patient observation by employees and, subsequently, adjusted policies and secured approval of additional staff. As a result of these changes, nursing leadership believes there is enhanced accuracy with staff documentation of observation onto flow sheets.

The facility's Escort Service policy was written for facility-wide use and does not address special needs of MH patients. Escorts could be either staff from the unit or others sent from the escort "pool." These other escorts had no specialized training in working with MH patients. According to unit practice, escorts accompanied patients on POLs 1 and 2, but were not required to remain with them throughout the appointment. Unit staff accompanied patients on POLs 3 and 4 and remained with them throughout their off-unit appointments.

Staff reported that many MH inpatients request appointments for treatments, such as dental care, that are available to them as inpatients but may not be as outpatients. Staff reported issues with specialty clinic wait times, which can be lengthy and unsafe for unaccompanied POL 1 and 2 patients. There have been no arrangements between the unit and the specialty clinics to have these patient appointments prioritized to decrease their wait time and associated risk factors.

Staff also raised concerns about the quality of the escort service for MH inpatients and reported that leaders had taken no action to address this issue. From our document review, we found the following examples of concerns regarding the lack of monitoring of escorted unit patients.

> A patient with active poly-substance use, self-injurious behavior (wrist cutting), and domestic violence charges was admitted and assigned POL 2. Four days into his stay, he went to radiology with an escort. The patient returned to the unit 4 hours later and informed the nursing staff that no escort had been available to escort him back, and that following his appointment, he "roamed through the building," visited the offices of his outpatient social worker and psychiatrist, picked up his outpatient prescriptions for testosterone and multivitamins at the pharmacy, and self-injected testosterone. There was no evidence that staff knew of the patient's whereabouts. Except for the submission of an incident report, there was no immediate action taken by staff, such as POL change, contraband search, provider notification, or UDS. The next day, the provider documented that the patient complained of "vomiting" and "persistent drenching sweats of unknown origin." There is no indication in the EHR that unit staff notified the provider of the patient's unobserved activities, including reportedly injecting testosterone, the day before.

Staff scheduled a 9:30 a.m. dental evaluation for a POL 1 patient diagnosed with schizophrenia. Since the patient had not yet returned by 1:30 p.m., the unit staff contacted the Dental Clinic staff who reported that the patient said he was going outside to smoke. MH staff then paged the patient and, more than 3 hours later, notified the facility police to initiate a missing person search. When the patient returned to the unit on his own at 6:00 p.m., he explained his delayed return was because he "got lost." An EHR nurse's note states that the patient provided a UDS per physician order, but there is no corresponding lab toxicology report. Although the staff searched the patient for contraband and changed his level to POL 4, there is no evidence that staff monitored the patient or followed-up on the missed UDS report.

Staff assigned the subject patient a POL 2 with 30-minute checks. Accordingly, staff escorted the patient to his ophthalmology appointment, and left him unattended in the waiting area. The clinic staff observed him to be friendly and talkative with other patients in the waiting room, and he appeared energetic to the point of having difficulty remaining seated. The patient used one of the clinic reception phones and was overheard arranging to see someone and saying "It's definitely on." Later, the patient did not respond when staff called his name to be seen, and he was missing from the clinic waiting area for an undetermined period of time. The patient eventually returned to the clinic, and the ophthalmologist evaluated him. Another employee casually mentioned to the unit staff that the patient did not remain in the clinic waiting area. Therefore, after escorting the patient back to the unit, staff searched him for contraband but found only matches. Staff also requested a urine sample for a UDS, but upon the patient's request, accepted an unobserved sample that he provided later that evening. (As previously described, this sample was actually another patient's urine and reported as "clean.")

These incidents illustrate the impact of an absence of clear guidance in providing safe escort service. MHSL and Nursing Leadership did not take any procedural action following the two incidents prior to the subject patient's death. During our September site visit, unit staff reported that POL practices remained unchanged, in spite of their requests for change. However, during our February site visit, unit leadership reported that practices were changed shortly after the subject patient's death to limit off-unit appointments to medical emergencies and discharge needs, and to require that only unit staff escort patients.

Issue 3: Inpatient MH Staffing

We did not substantiate the allegation that staffing on the unit was inadequate or that there was inappropriate assignment of outpatient care to inpatient psychiatrists and administrative duties to social workers.

We reviewed the unit's staffing and vacancy reports for July–September, 2012. Although a staffing report shows two of its five psychiatrists were assigned to 50 percent MH outpatient care, leadership and the two psychiatrists reported spending 100 percent of their time on the unit. Social workers acknowledged that although they may participate in various unit work groups and facility committees, these activities support the mission of the MHSL and do not detract from their clinical duties.

Nursing staff reported that they had adequate and appropriate staffing to meet the day-to-day needs of the unit including during the period of the patient's admission. In August, leadership approved hiring of additional nursing assistants based on the findings of a time study related to staffing observation and monitoring of patients. To further meet patient needs and provide unit staff as escorts to off-unit appointments, nursing leadership described using overtime hours and limiting the inpatient census.

Issue 4: MHSL Leadership and Patient Care

We did not substantiate that MHSL leadership does not care about patients.

Patients reported positive satisfaction with their care according to the Survey of Healthcare Experiences of Patients (SHEP) results for the first two quarters of FY 2012. The unit's scores surpassed both national and VISN 7 averages. The local Press Ganey Survey results for the 2nd and 3rd quarters of FY 2012 were consistent with the SHEP results. Additionally, the facility's patient advocate reports were without any significant trend or unresolved patient issue. The unit appeared clean, the treatment milieu was patient-centered, and there was current enhancement of the therapeutic activities schedule. Recently, unit leadership initiated a workgroup to develop a recovery model focus on the unit, further enhancing a team approach to patient care.

Issue 5: Leadership Follow-up Action and Staff Concerns

We found lapses in leadership follow-up actions in response to patient incidents and staff concerns.

We interviewed numerous employees who voiced frustration in the general lack of leadership action taken on the unit when adverse events occurred, particularly following the subject patient's death. The day after the patient's death, the unit Medical Director led an interdisciplinary staff meeting that identified areas of improvement for patient safety. Staff described the meeting as productive but expressed concern that leadership

had not implemented many of the suggested recommendations or updated them on progress.

In reviewing program oversight, MH leadership described conducting bimonthly interdisciplinary staff meetings but failed to document these meetings with meeting minutes. Unit staff told inspectors that these meetings were often canceled, were not attended by all relevant disciplines, and follow-up action taken to address issues raised during these meetings was lacking. The unit's leadership verbalized that they did not meet formally but had frequent ad hoc meetings to discuss issues. In September 2012, they conducted regular meetings to develop a recovery model implementation plan.[22]

The day of the incident was a federal holiday so administrative staff, including the unit Medical Director and Nurse Manager, were not on duty. For 2 days after the patient's death, unit leaders offered debriefings for available unit patients and staff. These debriefings were meant to reduce the stress and anxiety associated with the event. Although managers reported providing individual outreach to all staff on duty at the time of the subject patient's death; only one of four staff recalled meeting with a manager for such a purpose.

Issue 6: RCA

We reviewed the RCA completed for this case and had concerns regarding the RCA document review and follow up.

Since 1997, JC has mandated that facilities conduct RCAs to analyze sentinel events, including inpatient deaths. JC further dictates that facility staff are expected to be "[…] conducting a timely, thorough, and credible RCA; developing an action plan designed to implement improvements to reduce risk; implementing the improvements; and monitoring the effectiveness of those improvements."[23]

As required, the facility initiated an RCA following the subject patient's death. The RCA was conducted in accordance with guidance set forth by the National Center for Patient Safety (NCPS). The appointed RCA team members included MH unit staff who were either peers or in an authoritative role on the unit. While we understand that such a team would have insights into the unit's operation, it is our opinion that some team members, as process owners, could have been limited in their ability to recognize unit problems.

[22] According to the National Association of Social Workers, "The Recovery Model is based on the concepts of strengths and empowerment, saying that if individuals with mental illnesses have greater control and choice in their treatment, they will be able to take increased control and initiative in their lives."
[23] Agency for Healthcare Research and Quality, *Patient Safety Primers, Root Causes Analysis*, http://www.psnet.ahrq.gov/primer.aspx?primerID=10, accessed 12/12/2012.

The RCA team identified root causes that may have contributed to this adverse event. We identified additional contributing problems not mentioned in the RCA, including discrepancies with staff documentation on the patient observation flow sheets and a lack of unit staff awareness of observation policy.

We found that 2 months following the completion of the RCA, the facility leaders responsible for the recommendations had not initiated the follow-up action for all items.

Lessons Learned

A Cardiopulmonary Resuscitation Committee on this death identified suction tubing was not available and there were problems with interruption of chest compressions required for AED analysis.

MHSL leadership told OHI inspectors that steps have been taken to ensure functional and maintained equipment on the inpatient MH unit.

Conclusions

We substantiated the allegations that the facility had inadequate MHSL policies and specifically that there were no policies in place to address visitation or UDS on the unit. We found that the MHSL procedures for contraband, patient observation and monitoring, and escort were not adequate to ensure patient safety.

We identified inadequate program oversight including a lack of appropriate follow-up actions by leadership in response to patient incidents. In addition, we found that staff lacked confidence in management to address important issues in a timely manner, and to communicate with them.

We found several issues related to the RCA that raised concerns about the document review, implementation of recommendations, and follow-up.

We did not substantiate that inpatient MH unit staffing was inadequate or that psychiatrists and social workers had inappropriate assignments. We also did not substantiate that MHSL Leadership does not care about patients.

Recommendations

We recommended that the Under Secretary for Health ensure that:

Recommendation 1. VHA develops national policies that address contraband, visitation, urine drug screens, and escort services for inpatient mental health units.

We recommended that the VISN and Facility Directors ensure that the facility:

Recommendation 2. Inpatient mental health unit develops and implements policies that adequately address contraband, visitation, urine drug screening, and escort service.

Recommendation 3. Inpatient mental health unit employs safeguards for documentation that accurately reflect staff observation of patients.

Recommendation 4. Inpatient mental health unit strengthens program oversight including follow-up actions taken by leadership in response to patient incidents.

Recommendation 5. Strengthen and improve the RCA process to ensure that all information and documentation related to the event are reviewed and that follow up actions are completed and timely.

Recommendation 6. Improves communication with staff regarding debriefings and planned actions to address identified deficiencies.

Recommendation 7. Inpatient mental health units are equipped with functional and well-maintained life support equipment.

Recommendation 8. Evaluates the care of the subject patient with Regional Counsel for possible disclosure(s) to the appropriate surviving family member(s) of the patient.

Comments

The Under Secretary for Health and the Veterans Integrated Service Network and Facility Directors concurred with our recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 17-24 for the Under Secretary's and Directors' comments.) We will follow up on the planned actions until they are completed.

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

Appendix A

Under Secretary for Health Comments

Department of Veterans Affairs

Memorandum

Date: APR 0 9 2013

From: Under Secretary for Health (10)

Subj: Healthcare Inspection – Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Decatur, Georgia (VAIQ 7346832)

To: Assistant Inspector General for Healthcare Inspections (54)

1. The Veterans Affairs (VA) Office of Inspector General Office of Healthcare Inspections conducted an inspection to assess the merit of allegations that negligence and mismanagement by Mental Health Service Line leadership contributed to the death of a mental health unit inpatient at the Atlanta VA Medical Center.

2. I have reviewed the draft report and concur with the report's recommendations. Attached are corrective action plans.

3. Should you have additional questions, please contact Karen Rasmussen, M.D., Director, Management Review Service, at (202) 461-6643, or by e-mail at karen.rasmussen@va.gov.

Robert A. Petzel

Robert A. Petzel, M.D.

Attachment

Under Secretary for Health Comments to OIG's Report

The following Under Secretary for Health's comments are submitted in response to the recommendation in the OIG's report:

OIG Recommendation

Recommendation 1. VHA develops national policies that address contraband, visitation, urine drug screens, and escort services for inpatient mental health units.

Concur **Target Completion Date**: September 30, 2013

Under Secretary's Response: VHA recognizes the importance of providing national policy to the field regarding contraband, visitation, urine drug screens and escort services for inpatient mental health programs. VHA will send a memorandum to the field with guidance on these issues. The guidance provided will use the term "hazardous items" in place of "contraband," a less stigmatizing term than "contraband" which is typically used within prison settings.

Appendix B

VISN Director Comments

Department of Veterans Affairs **Memorandum**

Date: April 1, 2013

From: Director, VA Southeast Network, VISN 7 (10N7)

Subject: **Healthcare Inspection – Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Decatur, Georgia**

To: Assistant Inspector General for Healthcare Inspections (54)

I have reviewed the draft report and support the facility's concurrence and their corrective action plan as attached.

for Charles E. Sepich, FACHE

Appendix C

Facility Director Comments

Department of Veterans Affairs **Memorandum**

Date:

From: Director, Atlanta VA Medical Center (508/00)

Subject: **Healthcare Inspection – Mismanagement of Inpatient Mental Health Care, Atlanta VA Medical Center, Decatur, Georgia**

To: Director, VA Southeast Network 7 (10N7)

1. I have reviewed the draft report and concur with the report's recommendations. Attached is the Atlanta's VA Medical Center's corrective action plan for the report's recommendations.

2. Thank you for the opportunity to review the draft report. If you have any questions, please contact Vicki Heggen, Chief Quality Management at (404) 321-6111 (7653).

Sandy Leake, MSN, RN

Facility Director Comments

Director's Comments to OIG's Report

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

OIG Recommendations

Recommendation 2. Inpatient mental health unit develops and implements policies that adequately address contraband, visitation, urine drug screening, and escort service.

Concur **Target Completion Date**: Completed

Facility's Response: Several new policies/procedures (outlined below) were developed and approved through proper channels. Staff who would implement the policies/procedures were trained on the policies. All unit staff were provided with copies of the new policies.

- Contraband: A Protocol for the Control of Hazardous Items for Mental Health (MH) Patients was developed to include search requirements for patients, visitors, and staff, respectively. It also addresses education of visitors coming onto the MH inpatient unit.

- Visitation: A new visitation policy was immediately developed and implemented on the inpatient unit. Visitors sign in and go to a large common area where they visit and are supervised by unit staff. All staff have been educated on the process.

- Urine Drug Screens: Initially, an evidence based nursing protocol was established for monitored urine drug screen collection by the Clinical Nurse Specialist on the inpatient MH unit. The inpatient MH nursing staff responsible for implementation of the protocol were educated and other staff on the unit made aware of the protocol. Additionally, an Atlanta VAMC policy memorandum, Monitored Urine Drug Screen Collection was developed incorporating the process of urine drug screen collection throughout the facility.

- Escort: Patients are now only allowed off the unit for urgent appointments and are continuously accompanied by MH staff. This has been updated in our inpatient Psychiatry Standard Operating Procedure.

Additionally, a missing patient drill was held on October 24, 2012. The mock scenario involved a patient eloping off the inpatient MH unit. The drill tested the facility response, as well as the inpatient MH staff's patient search and verbalization of the observed urine drug screen collection. The MH staff followed the above new procedures appropriately.

Recommendation 3. Inpatient mental health unit employs safeguards for documentation that accurately reflect staff observation of patients.

Concur **Target Completion Date**: Completed

Facility's Response: Immediately after the event, patient pictures were added to the daily rounding sheets to ensure correct patient identification when performing rounds. The nurse manager, or designee, also initiated random checks of the patient observation boards to ensure staff assigned to checks are completing them correctly and on time. These checks are conducted on both day and night shifts at least 3 times per month.

Recommendation 4. Inpatient mental health unit strengthens program oversight including follow-up actions taken by leadership in response to patient incidents.

Concur **Target Completion Date**: Completed

Facility's Response: The facility implemented the Electronic Patient Event Reporting System (e-PER) July 2012. The e-PER is an enhancement from our previous reporting system in that it allows easier aggregation and sharing of the event to Managers and key staff for information and/or follow-up. This allows for easier tracking of follow-ups as well. MH inpatient leaders are now alerted to each event as it is reported in the e-PER. Additionally, Patient Safety provided Q1 FY 2013 MH aggregate events report to the MH Leadership for review and identification of improvement opportunities. This report is now provided quarterly.

Recommendation 5. Strengthens and improves the root cause analysis process.

Concur **Target Completion Date**: Completed

Facility's Response: Patient Safety has implemented a process for requesting all documents related to the event that are not located in the computerized medical record, be provided. Additionally, Facility

Leadership will strengthen the process to ensure the assignment and timeliness of actions.

Recommendation 6. Improves communication with staff regarding debriefings and planned actions to address identified deficiencies.

Concur **Target Completion Date**: Completed

Facility's Response: In the days immediately following the death, several debriefings were held for all staff. The debriefings occurred at various times of day, including early in the morning so that night shift staff could attend. All staff directly involved in the incident were encouraged to attend at least one of the debriefings. Within 1 week of the incident, the nurse manager talked individually with all the nursing staff who were directly involved in the incident. Each was offered a referral to the Employee Assistance Program, but all declined. The inpatient Mental Health Unit Medical Director spoke individually with each of the physicians and residents involved with the incident. Additionally, the Chaplain offered counseling to staff, some of whom took advantage of this.

The inpatient MH Leadership implemented an ongoing interdisciplinary work group to collaborate on issues affecting the unit. The group has collected feedback from front line staff on suggestions for improving unit processes.

Recommendation 7. Inpatient mental health units are equipped with functional and well-maintained life support equipment.

Concur **Target Completion Date**: April 15, 2013

Facility's Response: The concerns reported regarding the cardiopulmonary resuscitation suction equipment were reviewed by the Cardiopulmonary Resuscitation Committee on August 15, 2012. It was determined, through staff interview, that there was a suction machine on the crash cart, as well as tubing. The issue identified was that the tubing needed to be extended. Although the team did not immediately find it, extension tubing was located in the bottom drawer of the resuscitation cart. The extension tubing was obtained during the resuscitation and the delay did not impact the outcome of the resuscitation. Additional tubing extension has been connected to the portable suction machine for ease of accessibility.

There were no issues identified concerning functionality or availability of the automatic external defibrillator (AED). The inpatient MH unit is equipped with two monitor/defibrillators that can be utilized in the automatic mode (AED) or full manual defibrillator/pacemaker mode. Inpatient Mental Health compliance for required Daily Defibrillator checks for April to September 2012, was 100 percent. Mock resuscitation drills will be conducted quarterly on the inpatient MH unit for all shifts.

Recommendation 8. Evaluates the care of the subject patient with Regional Counsel for possible disclosure(s) to the appropriate surviving family member(s) of the patient.

Concur **Target Completion Date**: April 30, 2013

Facility's Response: Clinical disclosure was provided to the patient's parents by the Attending Physician at the time of the patient's death. The Facility, in consultation with Regional Counsel and re-evaluation of the case, will proceed with an institutional disclosure.

Appendix D

OIG Contact and Staff Acknowledgments

OIG Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Terri Julian, Ph.D., Team Leader Anthony M. Leigh, CPA, CFE Nelson Miranda, LCSW Melanie Oppat, MEd, LDN Michael Shepherd, MD, Physician Consultant Joanne Wasko, LCSW

Appendix E

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