



DEPARTMENT OF VETERANS AFFAIRS OFFICE OF INSPECTOR GENERAL

COMPANION PODCAST TRANSCRIPT

Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia April 2021

INTRODUCTION

Hello listeners! Thank you for listening to this companion podcast produced by the Department of Veterans Affairs Office of Inspector General. Companion podcasts summarize and increase awareness of VA OIG published reports and regularly feature those OIG employees who conducted the report, inspection, or investigation. Find all VA OIG podcasts online at va.gov/oig.

Dr. Terri Julian:

This is Dr. Terri Julian, Director of Mental Health Programs within the VA Office of Inspector General. I'm here with Stephanie Beres, Associate Director of Mental Health Programs.

Stephanie and I are going to discuss the report *Deficiencies in Care and Excessive Use of Restraints for a Patient Who Died at the Charlie Norwood VA Medical Center in Augusta, Georgia*. This report covers the multiple deficiencies in the care of a patient who subsequently died at the facility. The patient was diagnosed with schizophrenia, a chronic and severe mental illness that can include delusions and hallucinations, which may cause a person to lose touch with reality. The patient had a long history of inpatient mental health treatment admissions and aggressive behavior towards staff.

Stephanie, can you start us off by telling us more about how the OIG came to be involved?

Stephanie Beres:

The OIG received allegations through its hotline that the patient died due to being overmedicated and not having adequate psychiatric provider coverage or staff communication. The complaint also noted inadequate psychiatric provider coverage at the facility's Downtown Division. The Charlie Norwood VA Medical Center consists of the Downtown and Uptown divisions that are located approximately three miles apart. The Downtown Division includes outpatient and inpatient medicine and an emergency department. The Uptown Division includes inpatient and residential mental health services.

Dr. Terri Julian:

There were many aspects to this hotline inspection. Can you tell me why the patient was admitted to the facility in 2019?

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Stephanie Beres:

Sure. The patient came to the Uptown Division and was yelling and acting inappropriately. A psychiatrist completed an authorization for the patient to be transported to an emergency care facility to address the patient's mental health symptoms. The patient was brought to the Downtown Division emergency department and was admitted to a medical unit.

Dr. Terri Julian:

I'm confused. The transport to the emergency department was for mental health reasons but the patient was admitted to a medical unit. Not a psychiatric unit?

Stephanie Beres:

That's right. The patient was admitted to a medical unit for treatment of a low blood sodium level. What is important to know though is that the patient's low blood sodium was a chronic condition that was well documented in the patient's electronic health record. It was not a condition in need of immediate treatment.

Part of the problem was that the facility was not an emergency receiving facility since they did not accept involuntary mental health patients. If the patient had been transported to a mental health emergency receiving facility, we think the patient's mental health treatment needs would have been prioritized immediately. The complications in the patient's care that followed would likely have been avoided if the patient's mental health needs were addressed right away.

Dr. Terri Julian:

What were some of the problems that occurred following the patient's admission?

Stephanie Beres:

Shortly after arriving on the medical unit, the patient wanted to smoke and became agitated and verbally aggressive when staff denied the request to go out to smoke. Staff restrained and sedated the patient and transferred the patient to the intensive care unit to be placed on a ventilator due to concerns about respiration related to the sedation.

If the staff had addressed the patient's nicotine dependence, as VHA requires, the patient's agitation and distress may have been managed and the patient may have not needed restraint or sedation, which would have avoided the ventilation.

Dr. Terri Julian:

Is this where the involvement of a mental health provider could have made a difference in this patient's care?

Stephanie Beres:

Yes, definitely. Although a psychiatric nurse practitioner made medication recommendations, the assessment did not occur until the patient was already restrained, sedated, and on a ventilator and therefore the patient was unable to be assessed in a meaningful way. It would have been more effective if a mental health provider was involved to provide recommendations regarding the patient's mental health treatment and symptom management upon the patient's admission and certainly when the patient was agitated about not being able to smoke.

The failure to address the patient's mental health needs immediately resulted in the excessive use of restraints. For example, four days after admission, the patient, while still in restraints, was transported by ambulance to a non-VA mental health treatment facility. The non-VA mental health treatment facility did not accept the patient since the patient was in restraints and the patient was transported back to the facility. The patient arrived back at the facility after approximately four hours of transport in restraints. The patient was then taken out of restraints to go to the bathroom and the patient appeared disoriented. Shortly after, the patient experienced a cardiopulmonary resuscitation event and died.

Dr. Terri Julian:

The medical examiner determined that medications did not contribute to the patient's death and listed the cause of death as bilateral pulmonary thromboemboli, which is a potentially life-threatening condition, caused typically by blood clots that travel from the legs or other parts of the body and become lodged in arteries in the lungs, resulting in blood flow blockage. Based on this, the OIG did not substantiate that the patient died due to overmedication. However, the medical examiner did note the history of prolonged restraint. What caused the patient's prolonged restraint to happen?

Stephanie Beres:

We found staff ordered and initiated medical surgical restraint for the patient when the restraints were actually applied for behavioral control. The type of restraint order is very important because restraints for behavioral control require one-to-one observation and an assessment every 15 minutes with documentation every 2 hours. Medical surgical restraints, on the other hand, requires less monitoring with documented observation every 2 hours and a reassessment every 12 hours or less. Further, the patient remained in restraints for approximately 22 hours without a physician's order. We found the staff failed to properly implement orders and document observations consistently throughout the patient's restraint. We also found that nurses did not receive consistent ongoing education on restraint use and monitoring, as required by facility policy, and this lack of education may have contributed to improper restraint use for the patient.

The OIG also discovered that nursing staff documented that the patient refused heparin, which is a medication that reduces the risk of those blood clots that can cause a blockage in the lungs that caused

the patient's death. However, nurses did not tell the physicians that the patient refused the heparin and they did not educate the patient or the patient's family about the importance of the medication.

Dr. Terri Julian:

Was the patient's family involved in medical decision making since the patient was not able to communicate for some of the time?

Stephanie Beres:

This was another problem we found. Although there was a request for an assessment of the patient's decision-making capacity, mental health staff did not complete the assessment. In diving deeper, we found that staff did not address additional decision-making capacity assessment requests submitted over a prior 12-month period that included the request for the patient's assessment.

Since this decision-making capacity assessment was not done, the patient was viewed as able to provide informed consent for treatment and staff did not consider involving the patient's family in treatment decisions including the administration of heparin to avoid blood clots while the patient was in restraints.

Dr. Terri Julian:

And what about staff communication?

Stephanie Beres:

We found that the patient endured an unnecessary four-hour ambulance trip in restraints because facility staff did not communicate that the patient was in restraints and the receiving non-VA mental health treatment facility did not accept patients in restraints. We also found that the facility provider did not speak directly with the accepting physician or document the patient's informed consent to transfer or the transfer as VHA requires.

Dr. Terri Julian:

And what did you determine about psychiatric provider coverage at the facility's Downtown Division?

Stephanie Beres:

We found that the Downtown Division lacked adequate psychiatric providers to manage behavioral health emergencies, as required by facility policy. We also found that the facility lacked a consultation liaison psychiatrist and that this likely contributed to staff's failure to respond effectively to the patient's agitation and therefore contributed to mismanagement of the patient's mental health needs.

Following the OIG team's June 2019 site visit, the Facility Director requested a review of the mental health staffing levels and approved hiring as recommended by facility mental health leaders.

Dr. Terri Julian:

Did the patient get the mental health assistance needed before this admission?

Stephanie Beres:

We found some gaps. In 2015, staff flagged the patient electronic health record to alert staff that the patient may pose a safety risk. VHA requires a review of the patient record flag within two years. We found that the responsible facility committee reviewed the patient's record flag approximately three years after the flag was assigned following a disruptive behavior event.

Further, the committee did not provide input into the patient's management to mitigate violence risk following two incidents in late 2018, as expected. This was another missed opportunity to help the patient and likely contributed to mismanagement of the patient's mental health needs.

Dr. Terri Julian:

Stephanie, thank you for exploring the issues related to this patient's care and the inspection. The OIG team made 18 recommendations to the Facility Director that addressed each of the problems we identified.

VA has submitted actions plans to address the deficiencies, and the OIG will follow up on the planned actions until they are completed.

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