Administrative Closure

Follow-Up of Facility Response to Administrative Board of Investigation Findings and Recommendations
Harry S. Truman Memorial Veterans Hospital
Columbia, MO MCI# 2014-01698-HI-0432

The VA Office of Inspector General Office of Healthcare Inspections conducted a review in response to a letter from Representative Mike Coffman concerning an attack and subsequent death of a patient at the Harry S. Truman Veterans Hospital (facility) in Columbia, MO. On February 11, 2014, we conducted an onsite review to discuss actions[i] the facility had taken in response to recommendations from an Administrative Board of Investigation (AIB)[ii] tasked to complete an investigation after an inpatient on the facility's locked mental health (MH) unit attacked and fatally injured another inpatient. We reviewed the AIB report of facts and recommendations dated March 29, 2013; discussed the facility's actions in response to the AIB's recommendations with the facility's Director; and reviewed pertinent documents.

Background: The facility's 12-bed inpatient MH unit treats acute MH patients as well as geropsychiatric patients. The unit is the only MH unit at the facility. On December 2, 2012, a 78 year old male (Patient A) was admitted with a [redacted]. On January 29, 2013, a 33 year old male (Patient B) assaulted a neighbor, and on January 31, Patient B assaulted his parents. Later on January 31, he was arrested and admitted to the Missouri University Psychiatric Center (University) on a 96-hour emergency involuntary civil commitment. That night, a psychiatry resident who worked at the University and at the facility transferred Patient B to the facility's MH unit. On February 1, Patient B assaulted Patient A at 15:10. Patient A received treatment at the facility's emergency department, was returned to the MH unit, and was assigned a 1:1 sitter. The sitter was not informed about the assault. Soon after returning to the MH unit, Patient B assaulted Patient A again, and Patient A died as a result of the injuries inflicted during the assault.

Quality of Care and Patient Safety

The AIB determined several causes contributed to the incident—ineffective hand-off communication; lack of consistent, reliable communication between law enforcement agencies; MH unit staff reluctance to use restraints, seclusion, and aggressive pharmacologic management to deal with aggressive/assaultive patients; failure to provide a safe, alternate environment (for the victim); physician coverage (the inpatient unit did not have a dedicated inpatient attending physician with overall responsibility for the unit); mixed patient population on the MH unit; MH unit staff complacency concerning the risk of violent and disruptive behavior; and MH unit staff differing philosophies regarding treatment of violent and disruptive patients.

The AIB identified opportunities for improvement which included closing communication gaps during law enforcement and University security staff hand-offs to VA police; developing protocols for assault prevention and improving staff awareness and training in assault prevention; "relooking" at criteria for seclusion/restraint and ensuring staff feel supported if they make a decision to utilize one of these modalities; considering assigning a full-time inpatient attending psychiatrist who has authority and accountability over the inpatient program; identifying and

evaluating alternatives within and outside the facility for placement/transfer for patient victims after an assault; strengthening training requirements for staff in management techniques for violent and disruptive behavior; reviewing with MH unit staff the philosophy of the MH unit as a "restraint and seclusion free ward" in order to address whether divisions along the lines of this philosophy prevents the use of restraints and seclusion in appropriate circumstances to mitigate the risk of harm to others; and implementing proactive measures to create a safe MH unit environment, not unduly influenced by perceptions that disruptive and violent incidents are rare.

We learned that several changes have occurred, are in process, or are planned to occur:[iii] [iv]

- The facility Chief of Police completed memoranda of understanding[v] with local law enforcement agencies.
- Psychiatrists now conduct rounds on all new admissions and 96-hour emergency involuntary civil commitment patients prior to the daily morning interdisciplinary team meeting, and staff are required to ask specific patient history questions prior to admission. All facility psychiatrists have signed a document outlining tour of duty hours and expectations.
- Resident physician orientation, including documentation of hand-off communication at shift change, has been revised and formalized and is now implemented prior to starting on the unit.[vi] [vii]
- MH unit staff have received training and education[viii] [ix] [x] to: (1) elevate concerns and to call the Chief of Behavioral Health if concerns are not resolved,[xi] (2) consider the use of seclusion and restraints, (3) address inpatient violent and disruptive behavior, and (4) address MH unit culture change regarding prior reluctance to use seclusion and restraints.[xii]
- Medical-psychiatric beds are available and can be used to house psychiatric patients.

In response to one of the AIB's recommendations, the facility attempted to hire two inpatient psychiatrists but has not been successful despite employing the services of a search agency. Therefore, the practice model has not changed, and outpatient psychiatrists continue to rotate inpatient care responsibilities. A recent communication from the facility director concluded that, "With the changes made, improved communication between all involved in care and nursing staff reporting they are more comfortable calling Attending Psychiatrists and Chief of Behavioral Health if situations are not addressed, Truman VA is recommending to continue the current practice model."[xiii]

The case was also peer reviewed soon after the incident.[xiv] The peer reviewers found (b)(3):38 U.S.C. 5705 (b)(3):38 U.S.C. 5705 (b)(3):38 U.S.C. 5705. We agreed.

Because the facility initiated appropriate actions prior to our review, I am administratively closing this case. We have no recommendations.

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