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6/19/06

Inadequate Supervision of Patients and Failure to Report Incidents at the Northern Arizona VA Health Care System, Prescott, AZ
Project Number: 2006-01764-HI-0333

Administrative Closure

The Department of Veterans Affairs, Office of Inspector General (OIG), Hotline Division was contacted by an anonymous complainant regarding various allegations at the Northern Arizona VA Health Care System (the system), Prescott, AZ.

The complainant alleged that: high-risk patients (suicidal/Alzheimer's) are not being monitored by medical staff, a patient had over 100 incidents of violent behavior, and a patient with Alzheimer's left the facility and management did not immediately search for him. He further alleged that a suicidal patient, who recently returned from Iraq, was to be admitted to the Mental Health Unit but he ran out of the Emergency Room. Initially, this patient was being processed as suicidal, but admission documents were changed to indicate he was not suicidal so the medical center would not get in trouble.

The Office of Healthcare Inspections (OHI), Dallas Regional Office, conducted a telephone interview with the system director and associate director. They were both aware of the above concerns and had reviewed and addressed each allegation. The results of their review and the corrective actions taken are described below:

Allegation: High-risk patients (suicidal/Alzheimer's) are not being monitored by medical staff.

System managers are not aware of any issues in regards to the care of Suicidal/Alzheimer patients. We have a policy "Evaluation and Care of Suicidal and/or Potentially Suicidal Patients", where attention is paid to the possibility of suicide and appropriate evaluation and management procedures are implemented. We routinely conduct a Root Cause Analysis review of suicides or suicide attempts. No significant issues have been identified. We have a Dementia Special Care Unit located in our Extended Care and Rehabilitation Center. The unit provides a safe environment for dementia diagnosed residents.

The allegation was not substantiated, and no action was needed.

Allegation: A patient had over 100 incidents of workplace violence.

(b)(3):38 U.S.C. 7332
(b)(3):38 U.S.C. 5701, (b)(6)

The patient was admitted to the system on October 23, 2005, with a diagnosis of cellulitis of his left leg. He is a homeless veteran [redacted] adult antisocial behavior. The patient was first treated at the system on [redacted] Since then, he has been issued 13 Uniform Police Reports (UORs) for various documented offences. System police reported that he had an extensive arrest record and had spent time in prison. The patient had a "behavioral patient record flag on his electronic medical record that said that, except for emergency care, the patient has been banned from the Phoenix VAMC since [redacted]

(b)(6)

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(b)(3):38 U.S.C. 5701.(b)(6) On [redacted] system clinicians admitted the patient for treatment of cellulitis. At that time, the Police Chief recommended that the patient be banned from the system because of his past record at the Phoenix VAMC and the potential danger to staff and other patients. On [redacted] the Disruptive Behavior Workgroup reviewed the patient's case. Committee members advised that, because of the patient's urgent need for medical care and the fact that he had never exhibited violent behavior at the system, clinicians continue to treat the patient.

The patient was issued six UORs between [redacted], and [redacted] for smoking, demanding to smoke, loud voice, opening a donation can, disruptive behavior, and alcohol on his breath. The Disruptive Behavior Workgroup met on [redacted] and [redacted] and developed a plan of action for the patient's disruptive behavior. The patient was discharged on [redacted]. On [redacted], when the patient was denied a medication refill, he reportedly contacted a pharmacist and stated that maybe he should "bring his gun in to get his medications." On [redacted] the Disruptive Behavior Workgroup met to review this incident. The workgroup considered the patient's improving medical status and his increase in intimidating and threatening behaviors and made a recommendation to the Director that the patient be banned from NAVAHCS, except for emergency care. A letter to this effect was sent to the patient on [redacted]

(b)(3):38 U.S.C. 5701.(b)(6)

A criminal investigator from the Department of Veterans Affairs Office of Security and Law Enforcement conducted a focus review of the system's Police Program. The investigator reviewed all reported UORs since [redacted] Based on the patient's documented incident reports, the investigator concluded that, while the patient was disruptive, he was not violent.

(b)(3):38 U.S.C. 5701.(b)(6)

This allegation was not substantiated, and no action was needed.

Allegation: An Alzheimer's patient left the facility and management did not immediately search for him.

The patient is a [redacted]-year-old homeless veteran with a diagnosis of [redacted] persisting dementia; there is no documentation of a diagnosis of Alzheimer's in his medical record. On [redacted] the patient was admitted to the Domiciliary for humanitarian reasons and to help him obtain community resources and placement in an assisted living facility. He was alert and oriented to person, place, time, and situation.

(b)(3):38 U.S.C. 5701.(b)(6)

(b)(3):38 U.S.C. 5701.(b)(6); (b)(3):38 U.S.C. 7332.(b)(6)

On [redacted] the patient was not in his room at the midnight bed check. VA police were immediately notified (12:30 a.m. on [redacted]), but a full search was not initiated, as the licensed practical nurse (LPN) on duty noted that the patient was not a high risk patient. According to documentation, he was last seen in the domiciliary at 8:30 a.m. on [redacted] (domiciliary policy allows patients to come and go as they please, as long as they return to the facility by 10:30 p.m. each day). System police noted that the patient's vehicle was not in the patient parking lot and notified the local police and requested assistance in locating the patient. On [redacted] at 9:10 p.m., system managers were notified that the patient was at the Wickenburg, AZ hospital. On [redacted] the patient returned to the Domiciliary. On [redacted] the Chief of Police

(b)(3):38 U.S.C. 5701.(b)(6)

provided system managers a copy of the UOR regarding the incident and a Missing Patient Reaction Worksheet that had been completed by the LPN. The LPN had documented that the patient was not a high risk patient. However, she marked yes to a question regarding cognitive impairment.

(b)(3):38 U.S.C. 5701,(b)(6) On [redacted], system managers investigated the incident and concluded that staff had not complied with the July 2001 *Patient Protection/Search Procedure* policy for assessment of patient risk. The policy requires that a physician determine patient risk of danger and cognitive ability to make decisions. In this case, an LPN determined that the patient was not at risk.

The allegation was partially substantiated. Staff did not initiate a full search for the patient as alleged, but the patient did not have Alzheimer's, he was alert and oriented. System managers found that the domiciliary staff had not complied with policy. The Patient Protection/Search Procedure policy was reviewed with the domiciliary staff on (b)(3):38 U.S.C. 5701,(b)(6) [redacted]. In addition, the policy was revised and strengthened to ensure adherence to VHA Directive 2002-013, Management of Wandering and Missing Patient Events, dated March 4, 2002.

Allegation: A suicidal patient, who recently returned from Iraq, was in the process of being admitted to the Mental Health Unit and ran out of the Emergency Room (ER). Initially, he was being processed as suicidal, but admission documents were changed to indicate he was not suicidal so the medical center would not get in trouble.

(b)(3):38 U.S.C. 5701,(b)(6) The patient is a [redacted]-year-old veteran with a history of polysubstance dependence. System managers reviewed the patient's medical record and found no evidence that any documentation was changed or altered. According to the ER clinicians' documentation, this patient was not a suicidal patient but a narcotic seeking patient.

(b)(3):38 U.S.C. 5701,(b)(6) During the time period of [redacted] 2006, the patient was seen (b)(3):38 U.S.C. 5701,(b)(6) five times seeking narcotics. On [redacted], the patient presented to the system's Urgent Care Center (UCC) seeking narcotics. The UCC provider contacted the patient's private physician and was told that the patient had been given 60 tablets of the (b)(3):38 U.S.C. 5701,(b)(6) narcotic Percocet on [redacted]. The UCC provider was also told that on [redacted] (b)(3):38 U.S.C. 5701,(b)(6) the patient had returned to his private physician's office requesting a new Percocet prescription because he lost the Percocet he had received on [redacted]. The private (b)(3):38 U.S.C. 5701,(b)(6) physician refused to give him a new prescription. The UCC provider denied the patient's request for percocet.

(b)(3):38 U.S.C. 5701,(b)(6) On [redacted] the patient returned to the UCC seeking narcotics. He was seen by the UCC provider and by his Mental Health Provider. The mental health provider documented that the patient was cognitively impaired from opiate and benzodiazepine. Because of the extent of the patient's addiction and his combat related PTSD, the mental health provider recommended that the patient be admitted to the psychiatric unit at the Tucson VA Medical Center. However, the patient refused psychiatric care so the mental health provider initiated a Title 36 (involuntary commitment) process.

While waiting to be transferred, the patient's condition improved and he no longer was determined to be in imminent danger and, therefore, did not meet criteria for involuntary commitment. At that time the patient agreed to a voluntary admission for detoxification from benzodiazepines at the Tucson VAMC. However, before the transfer could be effected, he left the UCC in a vehicle with his girlfriend. The patient's psychiatrist documented that he remains at risk for overdosing because of his drug seeking/dependence but determined that he could not be committed. All opiates and sedative-hypnotics were discontinued and the patient's medical record was flagged to alert clinicians of his drug seeking behavior. A follow-up appointment was scheduled with the patient's addiction therapist and mental health provider.

(b)(3):38 U.S.C. 5701.(b)(6) On [redacted] the patient returned to NAVAHCS to re-establish care. He stated he had been living in Seattle with his parents.

This allegation was not substantiated, and no action was needed.

OHI Conclusions

Based on our review of the system's response to the patient's allegations, we concluded that managers had addressed all of the patient's allegations and teken action when appropriate. Therefore, we make no recommendations, and consider the issues closed.