Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00748-319

Healthcare Inspection

Management of Mental Health Care Concerns Clement J. Zablocki VA Medical Center Milwaukee, Wisconsin

July 27, 2017 (Reposted on August 3, 2017 – See page v for additional information)

Washington, DC 20420

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations received from Senator Tammy Baldwin in December 2015. The allegations focused on compliance with program policies and procedures, staffing, and quality of care provided to a mental health patient at the Clement J. Zablocki VA Medical Center (facility) Mental Health Residential Rehabilitation Treatment Program (MH RRTP) in Milwaukee, WI. The patient was in the Substance Abuse Rehabilitation Treatment Program (SAR) within the MH RRTP at the facility. Specifically, the allegations included the following:

- Staff do not follow MH RRTP program policies including monitoring access to the units, performing rounds, maintaining physical presence and engagement in the milieu on the unit, and executing measures to diminish the potential flow of contraband onto the unit.
- Inadequate staff are present on the units therefore, staff are assigned to multiple units and are not performing assigned duties.
- A physician prescribed a patient a higher than indicated Suboxone (buprenorphine/naloxone) dose.

In June 2016, Senator Tammy Baldwin submitted supplemental allegations raising safety concerns on the Acute Mental Health Inpatient Unit (AMHIU). Senator Ron Johnson had similar concerns. We conducted a second visit to the facility in August 2016 focusing on the safety and security concerns in the MH RRTP and the AMHIU. Specifically, the additional allegations were:

- The locked AMHIU is not safe and secure. A patient's friend visited and the patient was later found unresponsive in his room after taking non-prescribed medications. The friend was not checked for contraband. The failure to check for contraband contributed to the availability of non-prescribed drugs on the secured unit.
- The management and operations in the MH RRTP are not meeting clinical, safety and security standards established by the Veterans Healthcare Administration (VHA):
    - Staff are not conducting random contraband checks or limiting the flow of contraband onto the unit. These inconsistent practices may have resulted in a patient attempting suicide by an overdose and another patient having a syringe in his room.
    - An Administrative Investigation Board determined that the domiciliary was not safe or secure and made 16 recommendations.
    - A patient was denied admission to MH RRTP then left the facility and committed suicide.

During our second site visit interviews, some staff raised concerns regarding a high recidivism admission rate attributed to inadequate mental health aftercare appointments and follow-up. After our second visit, we received emails from facility staff with the names of two MH RRTP patients that may have received inadequate care.

We substantiated that staff did not consistently follow policies to address patient safety on the units. Specifically, we substantiated that MH RRTP staff were not consistently conducting or documenting rounds; maintaining physical presence and engagement in the milieu on the units; and, conducting regular and random contraband checks for public areas and at least 10 percent of individual rooms per week as required by VHA.[1] VHA further mandates that the program manager ensure that a written policy exists outlining these requirements, as well as procedures for detecting and preventing contraband from being brought onto the unit.

We substantiated MH RRTP programs were inadequately staffed; staff were assigned to multiple units, and staff did not perform all assigned duties (for example, security checks). VHA requires MH RRTPs to be adequately staffed and established under the facility MH services for clinical supervision. For the facility, VA Office of Mental Health Services staff recommended, and facility leaders agreed, that 30 staff were needed to monitor each unit 24 hours a day/7 days a week. The MH RRTP 24 hours a day/7 days a week staffing plan called for 24 domiciliary assistants (DA) and 6 licensed practical nurses. According to a March 2016 communication with OIG, facility leaders planned to hire and recruit a sufficient number of staff to meet the VA Office of Mental Health Services recommendation. Facility leaders were aware for more than a year of a DA staff shortage but could not tell us how long. After our first visit, we determined that staff members were assigned to multiple units 39 percent of the time, which is out of compliance with VHA guidelines. When comparing our reviews from February and August 2016, we found an 18 percent increase in staff assigned to individual units; however, staff were still not assigned to each unit as required by VHA.

Although closed caption television was used to monitor the MH RRTP, the facility only stored recordings for 30 days, which prevented our review of events more than 30 days in the past. As part of our assessment of rounds and staffing, we reviewed available recordings that included the 30 days prior to our site visits.

Additionally, we confirmed facility leaders had not assigned a dedicated psychiatrist to the MH RRTP. MH leadership determined that patients could see their assigned MH outpatient psychiatrist in the MH outpatient clinic by appointment rather than a psychiatrist assigned to the MH RRTP interdisciplinary team. Facility leadership subsequently acknowledged the importance of having psychiatrists physically located on the unit and participating in the interdisciplinary teams within the unit. As of September 2016, psychiatrists were physically located on the unit.

[1] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

We did not substantiate that a patient was given a higher than indicated buprenorphine/naloxone dose. The patient's provider prescribed a dosage of buprenorphine/naloxone, which was within suggested ranges for the patient's phase of treatment. We found no contraindications with the patient's prescribed medications and buprenorphine/naloxone. The patient was found dead in his room. The autopsy report attributed the cause of death as acute mixed drug toxicity, and classified the manner of death as accidental. Toxicology results indicated that the patient did not have buprenorphine/naloxone in his system.

Facilities are required to have both policies and processes in place to check for contraband to ensure patient safety on the AMHIU. Checks are to be conducted randomly as well as scheduled at times such as on admission, when patients return to the unit, when clinically indicated, and after patients have been with visitors. Additionally, each visitor must be educated to ensure contraband is not given to patients or brought on the unit to provide for safety on the unit for all patients. Based on an incident involving a visitor providing a patient contraband, we focused our review of the safety and security on the AMHIU visitation procedures including contraband checks. We substantiated that in spring 2016, the unit did not have a policy outlining visitation procedures and staff were not consistently checking AMHIU visitors for contraband. A patient was found unresponsive in his room due to an overdose on the AMHIU after having visitors who were not checked for contraband. In accordance with VHA Handbook guidelines, staff notified the VA Police who investigated the incident, facility leadership initiated an internal review, and managers issued a standard operating procedure for conducting visitor contraband checks in July 2016.

We could not determine that a failure to conduct random contraband checks led to an attempted suicide and a patient having a syringe in his room. The patient who allegedly attempted suicide by taking medications could keep his medications in his room; therefore, we could not determine if a contraband check would have made a difference. The patient who was found to have a syringe in his room was sent to the Emergency Department three times in one evening and after the second visit was found to have a syringe and other contraband items. We could not determine if a contraband check after the first Emergency Department visit would have made a difference because we do not know when he acquired the syringe.

We substantiated that an Administrative Investigation Board was conducted and board members issued 16 recommendations. One of the recommendations addressed enhancing safety and security in the MH RRTP. In August 2016, we found increased police presence including a drug-sniffing dog and a newly hired private security guard on site during late night hours. Facility leadership added key card readers to the entrances of the MH RRTP building; however, we found rounds for safety and security processes were inconsistently implemented and we were allowed into the building without being asked to identify ourselves or being checked for contraband.

We did not substantiate that a patient was denied admission to the MH RRTP SAR. We found the patient was discharged from the MH RRTP SAR due to his failure to comply with policies. According to the VHA Handbook, every patient seen in MH services is assigned a Mental Health Treatment Coordinator (MHTC) whose role is to ensure

continuity of care. We found that the MHTC was not identified in the patient's electronic health record.

We reviewed seven patients discussed by the complainant(s) and/or interviewees. We received the name of one patient but did not have exact identities of the other six patients. The facility had completed reviews for similar patient incidences which we are confident are the same listed in the allegation. Of the seven patients we reviewed, we were unable to find documentation in the electronic health records that MHTCs were identified. We requested verification from facility managers who were able to identify one of the seven patients whose MHTC had been identified.

We determined facility aftercare programs were available during day, evening, and weekend hours. We validated that six of the reviewed patients who required post discharge follow-up care appointments received appointments; however, not all of the patients attended the appointments.

We reviewed the two MH RRTP patients who were identified as possibly having received inadequate care and found the facility staff rendered appropriate clinical care.

We recommended that the Facility Director ensure:

- MH RRTP local policies are consistent with VHA's MH RRTP Handbook, and MH RRTP leaders and staff adhere to the policies.
- MH RRTP managers monitor compliance as outlined by VHA MH RRTP Handbook.
- The MH RRTP has adequate resources, including staff, as specified by the MH RRTP Handbook to provide a safe, therapeutic environment.
- Full implementation of the AMHIU visitation policy and monitor for compliance.
- Implementation of assignments of MHTCs to MH patients and strategies to enhance communication and coordination across MH clinical areas.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the report and provided acceptable action plans. (See Appendixes B and C, pages 35–39, for the full text of the Directors' comments). For Recommendations 3 and 4 marked completed by the facility, we will follow up on the facility's action plans to ensure that corrective actions have been effective and sustained. For the remaining open recommendations with identified target dates, we will follow up on the planned actions until they are completed.

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

This is being reposted on August 3, 2017, due to a copying error regarding Appendix C, Facility Director Comments. Specifically, the Agency comment to Recommendations 3 and 4 were identical which was an error. The information regarding Recommendation 4 has been updated and reflects the response initially received from VAMC Director. Upon notification of the error, we have corrected it.

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to assess allegations received in 2015 and 2016 from Senator Tammy Baldwin and Senator Ron Johnson regarding management and specific patient care issues of the Mental Health Residential Rehabilitation Treatment Program (MH RRTP) and Acute Mental Health Inpatient Unit (AMHIU) at the Clement J. Zablocki VA Medical Center (facility), Milwaukee, WI.[2]

Background

The facility is a 196-bed tertiary care facility that provides a broad range of inpatient and outpatient medical, surgical, mental health (MH), and specialty care, to include substance abuse treatment and domiciliary care.[3] The facility, part of Veterans Integrated Service Network (VISN) 12, has four community based outpatient clinics located throughout Wisconsin.

Veterans Health Administration MH Services[4]

Veterans Health Administration (VHA) offers MH services along a continuum of care ranging from acute inpatient locked MH unit stays to less restrictive environments in a residential treatment program, to aftercare and outpatient services. Patients receiving MH services transition from one level to another. Based on each patient's progress, he/she may transition into either a less restrictive level of care or a more intensive level of care as needed.

Residential MH Services

Domiciliary care consists of a health maintenance program (meeting the needs of patients requiring long-term institutional care) and a rehabilitative care program (assisting patients returning to non-institutional community living). In 1995, the domiciliary rehabilitative programs began evolving into the Domiciliary Residential Rehabilitation Treatment Program (DRRTP). Therapeutic and rehabilitative goals led VHA to re-align and establish VA DRRTP as MH RRTP care models.

VHA requires MH RRTPs to be adequately staffed and established under facility MH services for clinical supervision. Examples of the care models are Domiciliary Care for Homeless Veterans (DCHV), Substance Abuse Residential Rehabilitation Treatment

[2] The Substance Abuse Residential Rehabilitation Treatment Program is located within the MH RRTP.
[3] VHA Handbook 1162.02. *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)* December 22, 2010. This VHA Handbook was rescinded April 2017 but has not yet been replaced. VHA considers the 2010 Handbook to be in effect until a new Directive or Handbook on the matter is issued. The Handbook describes the Domiciliary Care Program as VA's oldest health care program that was established in the late 1860's to provide a home for disabled volunteer Civil War soldiers. The Domiciliary has evolved from a "Soldiers' Home" to an active clinical rehabilitation and treatment program for male and female veterans.
[4] Ibid.

Program (SARRTP), and Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program (PTSD-RRTP).[5]

Residential programs provide a 24-hour therapeutic setting for patients utilizing professional and peer support in a structured environment. Residential programs aim to provide rehabilitative and clinical care to address a range of problems related to medical, psychiatric, substance use, social, and vocational issues. Depending on the residential rehabilitative care model, services may include assessment and diagnosis; individual and group counseling; case management; work therapy; vocational counseling; living and social skills training; occupational and recreational therapy; peer support and self-help groups; couples counseling; medication management; and individual and/or group psychotherapy. Patients are expected to perform activities of daily living independently or with minimal assistance, and to be generally capable of medication self-management.[6]

The milieu[7] of a residential program provides some of the structure and security of an inpatient unit while promoting recovery, increased independence, and community re-integration within a less restrictive treatment setting.[8] VHA requires residential treatment settings to emphasize rehabilitative approaches that promote education and practice of self-care skills, including patients' self-management of their medication regime.[9]

VHA requires that MH RRTP staff conduct the following:

> *(1) At least one formal safety, security, and privacy self-inspection each month that documents observations and corrective actions taken (including work orders submitted).*
> *(2) Regular and random health and welfare inspections of both public areas and resident rooms to detect contraband and unsecured medications.*
> *(a) Inspections of all residents' rooms must occur daily to detect unsecured medications.*
> *(b) A minimum of 10 percent of resident rooms, lockers, and drawers must be inspected each week to detect contraband.*
> *(3) Rounds (excluding CWT-TR[10]) to ensure the safety and security of Veterans, staff, and visitors. Staff must conduct rounds every 2 hours of all public spaces, such as hallways, dayrooms, group rooms, stairwells, community bathrooms, etc., and document the findings.*
> *(4) Bed checks at approximately 11 p.m. and 6 a.m. These checks must coincide with the local daily procedures used to verify the physical presence of each resident. Based on a local assessment of high-risk behaviors or illness, staff may conduct increased checks on individual Veterans. These checks may take place on any shift, including nighttime bedroom checks.*

[5] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
[6] Ibid.
[7] Milieu is a common term used in the psychiatric community that refers to the physical or social setting in which people live or in which something happens or develops.
[8] VHA Handbook 1162.02.
[9] Ibid.
[10] Compensated Work Therapy Transitional Residences is a work restorative program that combines a work therapy program with transitional living residences.

> *(5) Health and welfare inspections of the Veteran's belongings at admission and random inspection of the Veteran's belongings upon return from pass.*
> *c. The Domiciliary Chief or MH RRTP Program Manager must develop written procedures for detecting contraband brought on the unit.*[11]

Substance Use Disorder Programs

Substance Use Disorder (SUD) programs are for patients meeting the diagnostic criteria for substance abuse or dependence.[12] VHA requires that "SUD treatment must be provided consistent with evidence-based treatment guidelines"[13] outlined in the Veterans Affairs/Department of Defense (VA/DOD) Clinical Practice Guidelines: *Management of Substance Use Disorder,* August 2009.[14][15] Inpatient and outpatient SUD programs are based upon the treatment needs of the patient. The VA SUD continuum of care includes outpatient services, intensive outpatient programs, opioid replacement therapies, residential rehabilitation, and acute hospital admissions.[16]

SARRTPs provide SUD treatment in a residential setting. According to VHA,

> *Veterans cannot be denied admission to an SARRTP…based solely upon length of current abstinence from alcohol or non-prescribed controlled substances, the number of previous treatment episodes, the time interval since the last residential admission, the use of prescribed controlled substances, or legal history. The screening process must consider each of these special circumstances and determine whether the program can meet the individual Veteran's needs while maintaining the program's safety, security, and integrity.*[17]

VHA Handbook further indicates the SARRTP (the facility uses the term SAR) "…is not the appropriate level of care to provide acute medically-managed or medically-monitored detoxification to Veterans at moderate to severe risk of withdrawal."[18]

Inpatient MH Services

Acute inpatient psychiatric units[19] provide intensive MH services to ensure safety and appropriate clinical interventions. According to VHA policy:

> *Since patients are admitted to inpatient units due to the severity of their symptoms, all mental health units must be secured (i.e. locked) in order to accommodate involuntary*

[11] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
[12] American Psychiatric Association Diagnostic and Statistical Manual V.
[13] VHA Handbook 1160.04, *VHA Programs for Veterans with Substance Use Disorders (SUD)*, March 7, 2012. This VHA Handbook was scheduled to be recertified on or before the last working day of March 2017 and has not yet been updated.
[14] Ibid.
[15] *VA DOD Clinical Practice Guidelines for Management of Substance Abuse Disorders*, August, 2009.
[16] VHA Handbook 1160.04.
[17] Ibid.
[18] Ibid.
[19] This is the general terminology used in the VHA Handbook 1160.06. For this report, the facility uses Acute Mental Health Inpatient Unit (AMHIU).

> *patients and patients who are temporarily severely agitated and at risk of harming themselves or others, as well as to provide safety and privacy by controlling access to the unit by others.*[20]

VHA requires:[21]

> *Family and visitors must be educated regarding safety on the unit for the Veteran and others and the need to ensure that hazardous items are not given to the Veteran or brought into the unit…If weapons or suspected illegal substances are discovered during a search for hazardous items or at any time, VA Medical facility police must be notified.*[22]

VHA also requires inpatient staff to provide assessments and ongoing reassessments to ensure suicide prevention and precaution procedures to mitigate risk for veterans on the unit. When hazardous items are found in a patient's possession or room "…the patient's clinical status must be reassessed and appropriate clinical action taken, such as patient education regarding safety, more frequent checks, placing the patient on 1:1 observation status, or other clinically appropriate intervention."[23]

Facility Residential and Inpatient MH Services

The facility's MH RRTP, which has 155 beds, consists of four different therapeutic programs on separate units (see pictorial illustration, Appendix A).[24] Each program has integrated policies and procedures that are unique to the therapeutic protocols. One of the four programs is the SAR.[25] The SAR allows patients with substance use disorders to receive intensive treatment in a supervised residential setting.

The facility AMHIU, a locked unit with 34 beds, provides short-term inpatient treatment. Primary treatment goals are patient stabilization and discharge into continuing outpatient care or transfer to more specialized inpatient care as needed.

MH RRTP Staffing Requirements

VHA's MH RRTP Handbook requires MH RRTPs to be adequately staffed and established under the facility MH services for clinical supervision. The handbook outlines specific staffing requirements including onsite supervision 24 hours a day/7 days a week. An employee must be present on each unit at all times, and "…staffing for all positions must be adequate to allow coverage, even in times of

[20] VHA Handbook, 1160.06, *Inpatient Mental Health Services*, September 16, 2013.
[21] Ibid.
[22] Ibid.
[23] Ibid.
[24] The MH RRTP program consists of the following: Unit A - Women's Program with 15 beds; Unit B- Domiciliary Care for Homeless Veterans (29 beds), Intensive Acceptance and Commitment Therapy (ACT) (8 beds), General Mental Health (2 beds), Operation Enduring Freedom/Operation Iraqi Freedom/ Operation New Dawn (8 beds); Unit C- General Mental Health (33 beds), Post-Traumatic Stress Disorder (10 beds), Substance Abuse Rehabilitation Program (2 beds); and Unit D- Substance Abuse Rehabilitation Programs (48 beds). Additionally a hoptel unit with 24 beds is located in Unit A.
[25] The facility refers to the Substance Abuse Residential Rehabilitation Treatment Program within the MH RRTP as SAR.

staff shortage or absence."[26] Additionally, the handbook requires that core staffing be based on the number of beds for each program.

Buprenorphine/Naloxone (Suboxone®)

The VA/DOD Clinical Practice Guidelines for Management of Substance Use Disorders recommends that pharmacotherapy, for example buprenorphine/naloxone, be offered to patients who meet opioid dependence criteria.[27,28] Buprenorphine/naloxone is a controlled substance that is a Food and Drug Administration approved opioid[29] medication for the treatment of patients with opiate dependence. Buprenorphine/naloxone is a combination medication with pharmacological properties that lower its potential for misuse, increase its safety in cases of overdose, and diminish the effects of physical dependency to opioids, such as withdrawal symptoms and cravings. Buprenorphine/naloxone should be used as part of a complete treatment plan including medical management, counseling, and psychosocial support.[30] Providers adjust buprenorphine/naloxone dosage based on the patient's medical history and whether the patient is in withdrawal or the maintenance phase of treatment.[31]

Self-Medication Management Program

The VHA MH RRTP handbook requires program managers to develop and implement a local policy for self-medication to include medication administration, education, monitoring, and secure storage, and to have established procedures and guidelines to assess an individual's level of care.[32] Controlled substances may be included in the self-medication program. Providers assess patients for independence in managing controlled substance medications. In the later stages of treatment, medications may be dispensed in 7-day quantities for patient self-administration.[33] The treatment team monitors this process during the community re-integration phase.

[26] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP),* December 22, 2010.
[27] The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) provides diagnostic criteria for opioid misuse disorder that includes cravings to use opioids and persistence in using opioids despite disruptions to functional activities and causing interpersonal problems. Accessed on 1/8/16.
[28] *VA-DoD Clinical Practice Guidelines For Management of Substance Use Disorders (SUD),* August 2009.
[29] Opiates are derived from opium, while opioids generally refer to the synthetic form of the drug. In this report, the terms are used interchangeably.
[30] *Clinical Guidelines for the Use of Buprenorphine in the Treatment of the Opioid Addiction; A Treatment Improvement Protocol TIP 40,* Substance Abuse and Mental Health Services Administration Center for Substance Abuse Treatment, DHHS Publication No. (SMA) 04-3939, Printed 2004.
[31] Buprenorphine/naloxone dosage guidelines differ depending on the individual's medical history and phase of treatment (i.e. withdrawal or maintenance therapy).
[32] VHA Handbook 1162.02.
[33] Self-medication management program scale encompasses Level I (dependent; nurse administers medications); Level II (semi-independent; patient receives a 7 day supply of approved medications) and Level III (independent; patient receives a 7 to 30 day supply of approved medications).

Urine Drug Tests[34]

An integral part of a substance abuse treatment program is urine drug testing/tests (UDT/UDTs[35]). Self-reporting of drug use has limited validity and monitoring behavior alone can fail to detect problems revealed by UDTs. Indications to change treatment intensity or provide adjunct therapy include relapse based on self-reporting or urine toxicology results.

The Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines recommend that information provided by UDTs extend beyond assessing compliance or detecting substance abuse. "When performed and interpreted properly, UDTs and confirmatory urine and blood drug tests can provide accurate and useful information that allows the clinician to tailor opiate treatment regimen." SAMHSA recommends, "…during opioid addiction treatment with buprenorphine, toxicology tests for all relevant illicit drugs should be administered at least monthly."[36]

MH Coordinators

According to the VHA Handbook 1160.01,[37] every patient seen in MH services is assigned a Mental Health Treatment Coordinator (MHTC) whose role is to ensure continuity of care.[38] When the patient sees more than one MH provider and when he/she is involved in more than one program, the identity of the MHTC must be made clear to the patient and identified in the electronic health record (EHR).[39]

According to VHA Directive 2008-036,[40] the Suicide Prevention Coordinator (SPC) "…is a position funded at each medical center as part of VHA's national suicide prevention strategy. The incumbent in this position is clinically trained and has the responsibility for coordination of local suicide prevention strategies…" The SPC is also responsible for maintaining the Patient Record Category II Suicide Risk flag (PRF) locally."

The MHTC must collaborate with the SPC in each facility to support the identification of those who survived suicide attempts and others at high risk and to ensure that they are provided with increased monitoring and enhanced care.[41]

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[34] *VA-DoD Clinical Practice Guidelines For Management of Substance Use Disorders (SUD*), August 2009.
[35] References cited use both terms; for this report, we use the terms interchangeably.
[36] Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*. Treatment Improvement Protocol(TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.
[37] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015. This Handbook was scheduled for recertification on or before the last working date of September 2013. The amendment in 2015 did not reset the certification date; it has not yet been recertified.
[38] The Office of Mental Health Services re-titled the Principal Mental Health Provider as the MHTC when the role and responsibilities changed.
[39] DUSHOM Memorandum, *Assignment of the Mental Health Treatment Coordinator*, March 26, 2012.
[40] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008. This directive expired July 31, 2013 and has not yet been reissued.
[41] VHA Handbook 1160.01.

Reviews of the Facility's MH RRTP

MH RRTP VA Central Office Consultative Site Visit (April 2015)

The VISN 12 Great Lakes Healthcare Network leadership requested and a VA Central Office (VACO) MH RRTP team conducted a consultative site visit and quality assurance review of the facility MH RRTP in response to concerns relayed by congressional stakeholders. Further discussion of the results of the visit/review is prohibited as the results are protected under 38 U.S.C. 5705.

Administrative Investigation Board (October 2015)

In October 2015, an Administrative Investigation Board (AIB) was convened in response to allegations received by congressional stakeholders. The complaints encompassed MH RRTP personnel issues and programming. The AIB issued 16 recommendations one of which addressed safety and security issues in the MH RRTP.

VISN 12 Great Lakes Healthcare Network Consultative Site Visit Report (November 2015)

In response to an MH RRTP patient's death (Patient 1), the VISN 12 Director requested a site visit to review the safety of the environment. A VISN 12 MH Team conducted a physical site visit on November 12, 2015. The team reviewed the patient's EHR, relevant documents, and the facility's progress with the VACO MH RRTP action plan. After completing the review, the consensus was that facility leadership had made progress toward improving safety but areas still needed improvement. The team "…could not determine with certainty that the patient's death could have been avoided if all of the VACO safety and security recommendations had been implemented."

OIG Unannounced Site Visit (February 2016)

In February 2016, we conducted an unannounced inspection of the MH RRTP building to evaluate accessibility, safety, and security of the building. We interviewed employees and leadership with relevant knowledge of the MH RRTP.

VISN 12 Great Lakes Healthcare Network Consultative Site Visit Report and AIB Follow-Up Report (April 2016)

The VISN 12 MH Team conducted a follow-up visit on April 11, 2016 to review the progress toward completing the recommendations from previous site visits and the AIB report. The VISN MH Team found that facility leadership "…made significant progress toward improving the safety and security…" of the MH RRTP programs and "…had remediated 14 of the 16 AIB recommendations."

VISN 12 Great Lakes Healthcare Network Director Site Visit (May 2016)

On May 11, 2016, the VISN 12 Director and MH Team conducted an MH RRTP site visit. The VISN team met with MH RRTP employees without leadership to give staff the

opportunity to communicate any concerns. After the site visit, the VISN team received positive e-mails about MH RRTP leadership.

OIG Unannounced Site Visit (August 2016)

We conducted a second unannounced site visit in August 2016 to address allegations similar to those received in February 2016 involving the MH RRTP and new allegations specific to the AMHIU. During our second site visit, we arrived at the MH RRTP building unannounced to evaluate accessibility, safety, and security of the building. We interviewed employees and leadership with relevant knowledge of the MH RRTP. Additionally, we interviewed AMHIU employees and any facility employee who requested to speak with us.

Allegations

In December 2015, we received a letter from Senator Tammy Baldwin regarding concerns for a patient (Patient 1) who was in the facility's SAR. Specifically, the concerns were (see Inspections Results: Allegations 1-3):

- Staff do not follow MH RRTP program policies including monitoring access to the units, performing rounds, maintaining physical presence and engagement[42] in the milieu on the unit, and executing measures to diminish the potential flow of contraband onto the unit.

- Inadequate staff present on the units therefore, staff are assigned to multiple units and are not performing assigned duties.

- A physician prescribed a patient a higher than indicated Suboxone (buprenorphine/naloxone) dose.

In June 2016, Senator Tammy Baldwin submitted supplemental allegations raising safety concerns on the AMHIU. Senator Ron Johnson had similar concerns. We conducted a second visit in August 2016, focusing on the safety and security concerns in MH RRTP and AMHIU. Specifically, the additional allegations were (See Inspection Results: Allegations 4-5):

- The locked AMHIU is not safe and secure. A patient's friend visited and the patient was later found unresponsive in his room after taking non-prescribed medications. The friend was not checked for contraband. The failure to check for contraband contributed to the availability of non-prescribed drugs on the secured unit.

[42] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP*), December 22, 2010. The handbook requires physical presence of staff on the unit and expects staff engagement when on the unit. For the purpose of this review, we considered engagement to be interaction between staff and patients.

- The management and operations in the MH RRTP are not meeting clinical, safety, and security standards established by VHA:

    - Staff are not conducting random contraband checks or limiting the flow of contraband onto the unit. These inconsistent practices may have resulted in a patient attempting suicide by an overdose and another patient found with a syringe in his room.

    - An AIB determined that the domiciliary was not safe or secure, and made 16 recommendations.

    - A patient was denied admission to the MH RRTP, then left the facility and committed suicide.

During our second site visit interviews, some staff raised concerns regarding a high recidivism admission rate attributed to inadequate MH aftercare appointments and follow-up. After our second visit, we received emails from facility staff with the names of MH RRTP patients that may have received inadequate care. We discuss these concerns in Patient Case Summaries 6–7 and in our Inspection Results.

Scope and Methodology

We initiated our review on January 11, 2016 and completed our work February 7, 2017. We made an initial unannounced site visit to the MH RRTP on February 16, 2016 and remained on site through February 18, 2016. We conducted an unannounced site visit to the MH RRTP August 1, 2016 and remained on site through August 4, 2016 to review additional allegations. We toured the MH RRTP units during both site visits and the AMHIU during the second site visit. We interviewed MH RRTP staff and managers, the MH RRTP Consultant, AMHIU staff and managers, MH leadership, VA Police, VISN MH leadership, facility leadership, and others knowledgeable about MH RRTP and/or the alleged events.

Due to concerns about retaliation for meeting with the OIG, we met with employees on site or at an undisclosed location at a time requested by the employee. We requested that facility leadership distribute an announcement through the facility e-mail system, intranet page, and in employee break areas outlining instructions on how to contact the OIG directly regarding information or concerns about MH programs.

We reviewed VHA directives and handbooks; facility policies and procedures related to inpatient and outpatient MH services; facility MH RRTP staffing; patient EHRs; and the Office of Milwaukee County Medical Examiner autopsy and narrative investigative

reports. We reviewed MH RRTP and AMHIU Closed Circuit TV (CCTV) tapes,[43] VA Police Reports, VISN Consultative Site Visit Reports, VHA Office of Mental Health Consultative Site Reports, VA OIG Office of Investigations reports, and quality management reports.

Unavailable CCTV tapes were a limitation for this review. The facility stored tapes for 30 days, which prevented our review of events that occurred more than 30 days prior to our awareness of the event. For example, we received allegations of possible harm to patients 2–3 months after the incidences occurred and the CCTV tapes were not available for review.

Another possible limitation was the positive identification of all patients mentioned in the allegations. We reviewed seven patients discussed by interviewees. We received the name of one patient but did not have exact identities of the other six patients. The facility completed reviews for similar patient incidences, which we are confident are the same individuals alluded to in the allegations or interviews.

We notified facility leadership of immediate concerns while onsite. We referred allegations of fraud, waste, and abuse to appropriate external and internal agencies. We referred interviewees to the Office of Special Counsel and the VA Office of Resolution Management for any concerns they had about reprisal, whistleblower protection, discrimination, or harassment.

Six policies cited in this report were expired or beyond their recertification dates:

1. VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010 (recertification due date, December 2015).
2. VHA Handbook 1162.05, *Housing and Urban Development – Department of Veterans Affairs,* September 14, 2011 (recertification due date, September 2016).
3. VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2009 (recertification due date, July 31, 2013).
4. VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (recertification due date, December 31, 2015).
5. VHA Directive 2007.005, *Compensated Work Therapy Supported Employment Services Implementation Plan* (expired December 31, 2011).

[43] At the time of the first visit, we obtained copies of CCTV tapes that were recorded on a compact disc for the MH RRTP units from eight different days including weekend, midweek, and holiday weekend days for the hours between 11:00 p.m. and 3:30 a.m. to review staff activity and presence of supervision. For the second site visit, we obtained copies for the MH RRTP using the same protocol as the initial visit with the exception of adding a holiday weekend. We obtained copies of the AMHIU tapes using the same protocol to evaluate adherence to a new visitation procedure at the time of our August evaluation.

6. VHA Handbook 1160.04. *VHA Programs for Veterans with Substance Use Disorders (SUD),* March 7, 2012 (recertification due date, March 2017).

We considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016 memorandum to supplement policy provided by VHA Directive 6330(1),[44] the VA Under Secretary for Health (USH) mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[45] The USH also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[46]

We **substantiate** allegations when the facts and findings support that the alleged events or actions took place. We **do not substantiate** allegations when the facts show the allegations are unfounded. We **cannot substantiate** allegations when there is no conclusive evidence to either sustain or refute the allegation.

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

[44] VHA Directive 6330(1), *Controlled National Policy/Directives Management System,* June 24, 2016, amended January 11, 2017.
[45] VA Under Secretary for Health Memorandum, *Validity of VHA Policy Document,* June 29, 2016.
[46] Ibid

Patient Case Summaries

Patient 1

The patient began receiving care at the facility in 2008. He had a history of inpatient and outpatient MH treatment related to SUD and other MH issues.

In 2015, the patient voluntarily presented to the Emergency Department (ED) requesting treatment for substance use after relapsing. He had been abstinent for 4 months before relapsing. ED providers admitted him directly to the AMHIU for detoxification.

On AMHIU day 2, he was prescribed buprenorphine 2 mg/naloxone 0.5 mg, sublingual for inpatient induction.[47] The provider assessed the patient's response to this medication using the Clinical Opiate Withdrawal Scale (COWS)[48] and made adjustments accordingly. On AMIHIU day 7, the provider transferred the patient to the MH RRTP SAR and adjusted the buprenorphine/naloxone to a maintenance dose (8mg/2mg);[49] he remained on this dose until his death on MH RRTP SAR day 11.

MH RRTP staff assessed the patient and determined he was Level I dependent under the safe medication program. He was required to go to the medication room and receive his medications from nursing staff.[50] The patient often received his medications several hours after designated dispensing times because he did not consistently present for his medications on time and staff were unable to locate him. Nursing staff would document administration of late medications.

On MH RRTP SAR day 9, the patient saw a Registered Nurse (RN) with complaints of vomiting. The RN placed the patient on bed rest for the rest of the afternoon and documented that nursing would monitor the patient. On the morning of MH RRTP SAR day 10, an RN saw the patient for complaints of nausea, vomiting, and diarrhea, and sent him to the ED for follow-up. The patient's EHR does not contain documentation that he received treatment in the ED on this day. When the patient went to the medication room on the evening of MH RRTP SAR day 10, he complained of nausea and a licensed practical nurse (LPN) encouraged him to drink fluids and to let nursing staff know if symptoms worsen. Later that evening, the patient complained of vomiting

[47] The induction phase is the medically monitored initial phase of buprenorphine treatment performed by a physician using approved buprenorphine products. The medication is administered when a person with an opioid dependency has abstained from using opioids for 12 to 24 hours and is in the early stages of opioid withdrawal.
[48] The Clinical Opiate Withdrawal Scale (COWS) is used to monitor the patient's signs or symptoms when the provider prescribes buprenorphine to ease opiate withdrawal.
[49] Maintenance dose is the amount of a medication administered to maintain a desired level of medication in the blood.
[50] VHA Handbook 1108.03, *Self-Medication Programs*, February 3, 2010. This Handbook was current at the time of the events discussed in the report; it was rescinded and replaced by VHA Directive 1108.83 *Self-Medication Programs*, November 28, 2016. The 2016 Directive has the same or similar definitions as the previous version concerning levels of independence for self-medication (Level I: dependent, Level II: semi-independent, and Level III: independent). See also, Professional Services Memorandum VII-29, Milwaukee Domiciliary Residential Rehabilitation Treatment Program (DRRTP) *Safe Medication Management*, December 2013.

and diarrhea to an LPN who wanted him to see an RN, but he refused evaluation by an RN. The LPN notified the RN of his condition.

In the morning of MH RRTP SAR day 11, he told an RN that he was feeling achy and had a sore throat. The RN placed him on bedrest for the day. He did not attend his designated medication dispensing time in the early evening. Five and half-hours later, his roommate found him unresponsive in his room. Staff called for assistance. The paramedics and VA police responded to the patient's room but the patient had no detectable pulse or vital signs.

The final diagnoses in the autopsy report from the Office of Milwaukee County Medical Examiner included acute mixed drug toxicity with drug paraphernalia found at the scene along with other evidence of non-prescribed drug use. The medical examiner listed the cause of death as acute mixed drug toxicity and the manner of death as an accident. The toxicology results indicated that the patient did not have buprenorphine/naloxone in his system.

Patient 2

In 2011, the patient transferred his care to the facility from another VA facility. He had a history of inpatient, residential, and outpatient MH treatment related to a SUD, PTSD, and other MH issues. He was scheduled for aftercare appointments, but did not consistently attend the aftercare programs.

Since 2015, he was admitted several times to the AMHIU and once to the inpatient medicine unit. The SPCs reactivated a PRF[51] for an 11-month time frame in 2013 and again for another 11-month period in 2016 and 2017. SPCs completed and reviewed Suicide Safety Plans (SSPs)[52] with the patient throughout the 2016-2017 timeframe.

In 2016, emergency medical service (EMS) brought the patient to the ED for treatment of a drug overdose. He indicated a desire to leave against medical advice (AMA). Before the patient could leave, the ED physician found him lethargic with shallow respirations and treated his symptoms with an emergency medication.

The patient agreed to admission to the AMHIU. Providers admitted him for detoxification and on arrival to the unit; staff searched the patient's personal belongings and found no contraband. The nurses closely monitored him every 15 minutes throughout the night. The patient denied suicidal or homicidal ideations, and any audio or visual hallucinations.

[51] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010. This directive expired on December 31, 2015 and had not yet been reissued. Clinicians place a PRF on a patient who is at high risk for suicide. The purpose of the PRF is to communicate to other treating clinicians that the patient is at high risk for suicide.
[52] Deputy Under Secretary for Health for Operations and Management. "Patients at High-Risk for Suicide." Memorandum. April 24, 2008. A SSP is a care plan developed with the patient as a means to mitigate the risk of suicide. The elements of the plan include identification of triggers, directions, and contact numbers to get help from providers or national hotline, identification of stressors, contact numbers of family members or significant others for help, and identification of means reduction.

The next day, AMHIU day 1, the patient's family member and friend came to visit. Approximately 2.5 hours after the visit, a nurse found the patient unresponsive in the shower. The Rapid Response Team was called, assessed the patient, administered an emergency medication, performed an electrocardiogram, and assessed his vital signs. The nursing supervisor reported the incident to the VA police as required by VHA.[53]

A family member contacted the nurse supervisor and stated that the friend who visited earlier brought him drugs. The nurse supervisor reported this information to the VA police and the patient was no longer allowed visitors on the unit.

The SPC completed a Suicide Behavior Report (SBR) and a physician and nurse completed assessments. Once medically stable, providers transferred the patient from the medicine unit back to AMHIU in the afternoon of the second day.

On AMHIU day 2, staff allowed the patient visitation with a family member only. Although he had scheduled individual and group therapy until his discharge on AMHIU day 4, he declined to attend the majority of group therapy sessions.

Staff provided the patient MH aftercare within the specified timeframes as required by VHA. MH clinicians, including the SPC and Veterans Justice Outreach[54] Coordinator, continued providing services until the patient moved to another state 3 months later.

July 2017 OIG Update: As of July 13, 2017, the patient was receiving care at another VA facility.

Patient 3

The patient began receiving his care at the facility in 2011. He had a history of inpatient, residential, and outpatient MH treatment. Since 2014, providers activated and deactivated the patient's EHR PRFs[55] on several occasions at varying intervals. The patient was scheduled for aftercare appointments but did not consistently attend.

From 2014 to 2016, the patient had several admissions to the facility AMHIU and MH RRTP and another VA facility residential treatment program.

The next documented contact with the patient at the facility was in 2016, more than a year later, after he made a call to the VA National Suicide Prevention Hotline. The hotline responder counseled him and arranged for the local police department to escort him to the facility. Facility providers admitted him to the AMHIU for exacerbation of depression with SI with a plan and initiated the CIWA protocol. The SPC evaluated him

[53] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013, amended November 16, 2015.
[54] The Veterans Justice Outreach program provides outreach to veterans involved with the criminal justice system. The Veterans Justice Outreach program specialist provides case management services and serves as a liaison between the VA and the local criminal justice system.
[55] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010.

and determined he did not meet the criteria for placement on the high risk for suicide list or a PRF on his EHR.

After a 4-day stay in AMHIU, staff transferred and reoriented him to the MH RRTP program and provided a program packet containing guidelines and rules. Staff conducted a random contraband inspection and found nothing. Nursing assessed him to be a self-medication management Level III Independent.[56]

The patient was evaluated for the facility MH RRTP Domiciliary program and subsequently admitted.[57]

On MH RRTP day 49, the patient presented to a SW's office and stated that he ingested several prescribed pills. The SW immediately contacted nursing staff and VA police. Staff contacted EMS and transferred him to the facility ED via ambulance. Staff performed a contraband check of his room and found nothing. After stabilization in the ED, staff transferred him to the AMHIU. The SPC completed a SBR and SSP, put him on the high risk for suicide list, and placed a PRF on his chart.

Two days later, staff discharged the patient from AMHIU and admitted him to the MH RRTP Domiciliary program. Providers placed an order for Level I dependent self-medication protocol after his report of taking several prescribed pills. The next day, without notifying the MH RRTP Domiciliary staff, the patient presented to the ED stating that he was going to harm himself. Staff readmitted him to AMHIU for 5 days. Staff encouraged him to return to the facility domiciliary, but he decided to be discharged to a family member's home until he was admitted to a residential treatment program at another VA facility, 9 days later. During the interim stay at the family member's home, the facility SPC provided follow-up and transferred the responsibility of overseeing the PRF upon the patient's admission to the other VA facility.

July 2017 OIG Update: As of July 13, 2017, the patient was receiving care at another VA facility.

Patient 4

The patient presented to the facility in 2014. A provider evaluated him for two specified conditions during a compensation and pension appointment.[58] He had a history of inpatient, residential, and outpatient MH treatment related to PTSD and other MH issues. He received clinical services from the Suicide Prevention[59] and MH RRTP

[56] Self-medication management program scale encompasses Level I (dependent; nurse administers medications); Level II (semi-independent; patient receives a 7 day supply of approved medications) and Level III (independent; patient receives a 7 to 30 day supply of approved medications).
[57] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
[58] Compensation and pension examination is a comprehensive general medical or psychiatric examination to determine whether a current diagnosed disability is related to an event or injury or disease incurred or aggravated during military service.
[59] VHA Manual, *Suicide Prevention Coordinator Guide*, August 21, 2014.

programs. A PRF[60] had been activated and was transferred to other VA facilities throughout 2016. Aftercare appointments for treatment at the facility and other VA facilities were given to him but he did not consistently attend outpatient programs.

After his initial compensation and pension appointment, the patient did not seek treatment at the facility until the end of 2015 when he presented to the ED for symptoms related to PTSD and other MH issues. Staff admitted him to the AMHIU for exacerbated PTSD symptoms. Upon admission, his discharge plan was to transfer into MH RRTP but on the actual discharge date, the patient opted to return to his home and attend aftercare in the community.

In 2016, the patient was seen in the facility ED on several occasions, admitted to other VA facilities on two different occasions, and re-admitted to the facility's MH RRTP.

During the MH RRTP admission, the patient complained of pain to nursing staff, which he attributed to a prior surgery. Nursing staff transferred him to the ED for further evaluation. ED staff ordered pain medication, an ultrasound, and computerized tomography (CT) scan; the tests showed no acute findings.

When the patient returned, unescorted, to the MH RRTP from the ED, he appeared to be under the influence of alcohol. Nursing staff administered a breathalyzer[61] test, which was positive for alcohol consumption. Staff transferred him back to the ED and once medically stabilized, VA police escorted him to the MH RRTP.

An MH RRTP domiciliary assistant (DA) and nurse conducted a contraband check in his room and found a syringe in a package and a 3 ml syringe containing approximately one ml of blood. The nurse found the patient's right index finger bleeding. The patient stated that his community provider gave him the syringes to administer insulin for recently diagnosed diabetes. Staff also found 45 tablets of an anti-anxiety medication in his possession. Staff notified the VA police and gave the medications and syringes to them. Staff and VA police escorted the patient to the ED.

When the patient arrived at the ED, he requested admission to the AMHIU and pain medication. He admitted to taking the contraband syringes from one of his earlier ED visits. Staff admitted him to the AMHIU and placed him on CIWA and COWS protocols.

He was discharged AMA from the AMHIU the same day as admission. Staff reviewed his SSP prior to discharge but he declined VA aftercare services. MH staff made follow-up calls and mailed aftercare plans to him. When contacted, he reported that he was doing fine and attending aftercare meetings in his community. He denied any SI, plans, or intent. An SPC contacted other VA facility SPCs where the patient had received care previously to ensure continuity of care.

[60] VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010.
[61] A breathalyzer is a device that measures the amount of alcohol content from a sample of a person's breath.

July 2017 OIG Update: As of June 29, 2017, the patient was receiving care at another VA facility.

Patient 5

The patient began receiving care at the facility in 2010 post discharge from the military. He had a history of MH inpatient, residential, and outpatient treatment related to MH conditions.

The patient sought MH treatment in 2015 when he contacted the VA National Suicide Prevention Hotline.[62] The facility received a report generated by the hotline and the facility Suicide Prevention Manager contacted the patient and arranged for MH outpatient treatment the same day. After an initial assessment, providers recommended inpatient treatment. The patient refused but agreed to outpatient treatment. Within a month, a family member brought the patient to the ED after attempting suicide by ingesting multiple medications with alcohol. He was admitted to AMHIU from the ED. After 2 days, AMHIU providers discharged him AMA with MH aftercare appointments for follow-up treatment. He sporadically participated in aftercare.

In the following months, the patient was seen in the ED or admitted to the facility on several occasions related to his MH conditions but left against medical advice. Facility staff would make post discharge follow-up calls and aftercare appointments.

During one admission to the MH RRTP, he participated in individual and group sessions focused on but his attendance became inconsistent. The MH RRTP team addressed the inconsistent therapy attendance and other concerns with the patient. MH RRTP staff planned to discharge him from the program. Prior to discharge from the MH RRTP, the patient was overheard on the telephone making suicidal threats and staff called the VA police to escort the patient to the ED.

After a brief stay in the ED and an acute medical unit, the patient was transferred back to MH RRTP and discharged. Staff provided the patient with discharge instructions, advised him to attend all aftercare, and scheduled MH and primary care provider appointments. He had a PRF on his EHR but the SPC was not notified of his discharge.

The next day, the patient missed his scheduled outpatient appointment and his psychiatrist attempted to contact him. Two days after discharge, the patient spoke with an RN at the facility nursing telephone triage center requesting help. The nurse transferred him to a management support assistant in the outpatient MH clinic. The management support assistant spoke with him on the phone and notified clinicians of the patient's request for treatment options. A SW attempted to contact the patient 2 days later and left a voice message on his phone.

[62] The VA National Suicide Prevention Hotline is a 24 hours a day/7 days a week confidential veterans crisis line established to assist veterans in crisis situations. Specially trained staff assist veterans to cope with MH issues or homelessness through crisis intervention counseling and referring them to appropriate services in their community.

The patient was found dead 3 days after he was discharged from the MH RRTP SAR program. The SPC completed an SBR and VHA Issue Brief and a facility team completed a root cause analysis (RCA) as required.

Patient 6

The patient had a past medical history significant for depression with several admissions to the facility between 2013 and 2016 as well as an admission to another VA MH RRTP in 2014.

After one admission to MH RRTP, he was transferred to the Domiciliary program. During the MH RRTP admission, he was compliant with individual and group therapy and reported compliance with attending community support meetings. However, he was repeatedly non-compliant with follow-up with his assigned psychiatrist. About 5 weeks after his transfer to Domiciliary program, the patient reported to nursing staff that he was having difficulty sleeping. Nursing staff sent a note documenting his complaints through the EHR to his assigned psychiatrist. Three days later, the psychiatrist added an addendum noting she had not seen the patient for almost 1½ years and that he had not come for any follow-up appointments after his initial appointment. She documented the patient would need to reschedule an appointment with her to address his sleeping concerns. Approximately 3 weeks later, the MH RRTP nurse practitioner evaluated the patient and prescribed a medication to treat his insomnia.

About 9 weeks after his transfer to the domiciliary program, staff granted the patient an off-grounds pass to attend a treatment program in the community. At the time the pass was granted, the patient's therapist documented no suicidal or homicidal ideation or plan. Approximately one hour later, the Milwaukee police notified the facility that the patient had completed suicide. Facility staff provided bereavement counseling to the patient's family and completed an SBR and VHA Issue Brief.

Patient 7

This patient had a past medical history significant for PTSD, anxiety, and other MH issues. He had been treated at multiple VA facilities over 17 years. He was seen at eight different VA facilities in 2016. The facility SPC placed a PRF in the patient's EHR in August 2016.

The patient was admitted to the facility MH RRTP in 2016. Within a few weeks, MH RRTP staff determined he was Level II (semi-independent) under the safe medication program, and nursing staff documented providing him a 5-day supply of approved medications and instructing him to return every 5 days for medication refills. He did not return for a refill of his medications for 7 days. Nursing staff noted his container was empty and restated the process for refilling every 5 days. He verbalized understanding and said he would come back in 5 days. He came 5 days later to refill his medication as instructed.

Three days prior to discharge from the MH RRTP, the patient attempted suicide by ingesting multiple doses of two of his medications.[63] During a scheduled discharge planning session, he reported the suicide attempt to his therapist. The patient admitted that he had a great deal of anxiety associated with his upcoming discharge. Staff immediately escorted the patient to the ED and subsequently he was admitted to the AMHIU for overnight observation and discharged the following day. An SPC completed an SBR, met with him several times, and completed an SSP.

Three days post discharge, the patient presented to his scheduled primary care and MH appointments. He reported that he was living in a hotel and requested help getting into assisted living. The MH provider noted that he "already seems to be decompensating" after his discharge from inpatient treatment, and noted that the patient needed weekly MH appointments, but the patient declined to schedule follow-up appointments at that visit. A SW recommended intensive case management services through Mental Health Intensive Care Management (MHICM)[64]. Staff made several unsuccessful attempts to reach the patient to schedule these appointments.

Seven days later, he presented to a community ED with a diagnosis of agitation. He was placed on a 72-hour hold[65] at a county MH facility. Facility staff documented multiple unsuccessful attempts to reach the patient, including phone calls and mailed letters.

July 2017 OIG Update: The patient made contact with facility staff and was receiving services from the facility as of July 14, 2017.

Inspection Results

Allegation 1: MH RRTP Program Policies Are Not Being Followed by Staff

We substantiated that staff did not consistently follow policies to address patient safety on the units. Staff did not adhere to VHA MH RRTP program policies that required monitoring access to the units, performing rounds, maintaining physical presence and engagement in the milieu on the unit, and executing measures to diminish the potential flow of contraband onto the unit.[66] We also found that MH leadership did not monitor staff compliance to program policies.

[63] One medication was ordered for a MH condition and the other was a medication commonly used to treat the symptoms of allergies or colds.
[64] MHICM is a program that provides intensive case management services to serious mentally ill veterans who frequent MH services. The overall goal of the program is to optimize health and quality life in the community.
[65] A 72-hour hold provides MH professionals the opportunity to further evaluate an individual in a safe environment on a MH inpatient locked unit. The facility can legally prevent an individual from leaving until it is determined that the individual is no longer a danger to themselves or others.
[66] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP),* December 22, 2010.

Monitoring Access to the Units.

We substantiated that MH RRTP staff were not consistently monitoring access to the units.

VHA requires

> *…each MH RRTP (except Compensated Work Therapy-Transitional Residences) secures all entrances and egress doors to the unit and maintains a single point of access utilizing keyless entry and Closed Circuit TV (CCTV) monitoring. All other entrances and egress doors must be alarmed (to alert staff to an emergency or unauthorized opening) and monitored by CCTV. Larger MH RRTPs with multiple residential programming areas may provide more than one entrance and egress access point.* ***NOTE****: MH RRTP staff may open the main entrance to the unit during normal business hours as long as adequate staff are present on the unit to ensure that only authorized patients, staff, and visitors access the unit."*[67]

At the time of our first visit, the facility did not have a written visitation policy. We interviewed staff who acknowledged they did not have a written policy, but referred to an unwritten procedure that addressed patient visitation. This procedure included staffing the visitor desk with an incentive therapy worker[68] or DA, as needed. Managers instructed the visitor desk staff to ask the visitors to sign in on a visitation log and remain in the main area or visitation room. When we discussed the unwritten procedure with staff, they did not reference conducting contraband checks.

During our unannounced site visit of the MH RRTP on the evening of February 16, 2016 we found:

- The door was not locked and did not have a keyless entry system.
- No alarm sounded when we entered the building.
- No one was attending the visitor desk to ask us to sign a visitation log.
- No one asked us to identify ourselves while we walked throughout the units.
- No one offered to escort us throughout the MH RRTP building.
- More than one unsecured egress and access point to the building and units.

CCTVs were on each unit and throughout the building; however, CCTVs were not consistently monitored.[69] Managers and staff acknowledged visitor desk coverage was not 24 hours a day/7 days a week, nor was the desk located where staff could

[67] VHA Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program (MH RRTP), December 22, 2010.
[68] Incentive Work Therapy is a work restorative program operated in VA Residential Rehabilitation and Treatment Services to assist veterans with disabilities to obtain competitive supportive employment in the community as outlined in VHA Directive 2007.005, *Compensated Work Therapy Supported Employment Services Implementation Plan.* January 18, 2007. This VHA Directive expired December 31, 2011 and has not yet been updated.
[69] VHA Handbook 1162.02.

continuously monitor the main entrance. Without continuous coverage at the main entrance and with unsecured doors to each unit, access to non-visitor areas was relatively unrestricted throughout the building. Facility leadership projected an installation date of April 2016 for a keyless entry at the front MH RRTP entrance.

During our unannounced visit on the evening of August 1, 2016, we confirmed the installation of the keyless entry at the front MH RRTP entrance. We attempted to access the building but the door was locked. From the outside of the building, we could see a DA at the visitor desk that had been moved to a different location to allow continuous monitoring of the front MH RRTP entrance. We used the external speaker system to communicate with the DA who did not speak to us, but activated the mechanism that opened the door. As we passed the visitor desk, we observed sign-in sheets on the desk and lockers for visitors' belongings. The DA did not ask us to sign in or put our belongings in the locker.

We walked past the visitor desk, approached Unit A, and were unable to access Unit A because a key card was needed. Nursing staff spoke with us as we were returning from Unit A. We identified ourselves; staff did not ask to verify our credentials or immediately provide an escort. We walked through a second unit, the common area, and were in the third unit before a staff member came to escort us for the remainder of our visit.

With the exception of Unit A, we found unsecured doors and unrestricted access to each unit. An incentive work therapy employee was stationed at the back entrance of the MH RRTP and was monitoring access to the smoking shelter located behind the MH RRTP.[70] Before identifying ourselves to the incentive work therapy employee, we observed him diligently monitoring the signing in/out of residents and staff as well as checking bags. As noted on the first visit, VA Police remotely monitored CCTVs. The DA on the unit monitored CCTVs when he/she was present in the office where the CCTV monitoring devices were located.

Performing Rounds.

We substantiated that MH RRTP staff were not consistently conducting or documenting rounds.

VHA requires several types of rounds[71] including security and safety checks to be conducted and documented every 2 hours.[72] MH RRTP staff told us that they use a document entitled Daily Security Checks for security and safety checks. We requested the MH RRTP daily security checklist documentation from FY 2015. A facility manager reported that per unwritten procedure daily security checklists were not kept for more

[70] Smoking shelter was located outside the MH RRTP building and accessible to the main facility. It was used by patients, facility staff, and visitors.
[71] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP),* December 22, 2010.
[72] Ibid.

than 60 days. Facility staff provided daily security checklists dated December 1, 2015 through February 14, 2016 (those available at the time of our request).

The VA Police retain CCTV tapes for 30 days. At the time of our first visit, we requested MH RRTP CCTV tapes and reviewed tapes from 8 separate days including weekend, mid-week, and holiday weekend hours between 11:30 p.m. and 3:30 a.m.

We compared our observations of the facility CCTV tapes with documentation of the daily security checks. Staff documented rounds numerous times throughout their shifts. However, according to times on the CCTV tapes, staff did not conduct rounds consistent with written documentation for all but one unit.

During our August site visit, we requested and reviewed additional MH RRTP CCTV tapes from units that had inconsistent documentation as described above. We compared them with documentation on the daily security checks. We reviewed 10 separate days including weekend, mid-week, and holiday weekend hours between 9:00 p.m. and 6:00 a.m. We found, similar to the first site visit, staff documented rounds numerous times throughout their shift but according to times on the CCTV tapes, staff did not conduct rounds consistent with written documentation.

Physical Presence and Engagement on the Unit.

We substantiated that the MH RRTP staff were not consistently maintaining physical presence and engagement in the milieu on the units.

VHA requires that staff be physically present on the unit at all times when patients[73] are on the unit and expects staff engagement when on the unit.[74] For the purpose of this review, we considered engagement to be interaction between staff and patients. At the time of our February 2016 unannounced site visit, we observed staff on Unit A. We did not observe staff on some units, particularly units C and D. We spoke with patients who confirmed that MH RRTP staff remained in the common areas.

The CCTV tapes we reviewed after the August visit covered periods while we were not onsite[75] and showed staff inconsistently interacting with patients on Units C, D, and E when staff conducted periodic rounds. However, we did not observe interactions of staff with the patients on Unit B.

While evaluating staff presence on the unit, staff we interviewed told us that MH RRTP staff who were scheduled to work as documented on the work schedule were not always present on the unit. We requested staffing and leave schedules from January 31, 2016 through February 15, 2016. We compared the schedules with CCTV tapes

[73] We use the word patient to refer to veterans and residents. VHA uses veterans and residents interchangeably in VHA Handbook 1162.02.
[74] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP),* December 22, 2010.
[75] Tapes were not reviewed for Unit A because staff are posted on the women's unit 24 hours a day/7 days a week.

and we confirmed that the employees listed on the work schedules were at work. We repeated this process during our second site visit for the timeframe of July 4, 2016 through July 31, 2016 and confirmed that the employees listed on the work schedules were at work.

Executing Measures to Diminish the Potential Flow of Contraband onto the Unit.

We substantiated that MH RRTP staff were not consistently conducting contraband checks as required by VHA.[76]

VHA requires MH RRTP staff to conduct regular and random health and welfare checks in public area, private areas, and patients' rooms to detect contraband and unsecured medications; daily inspections of all rooms to detect unsecured medications; and weekly inspections of 10 percent of patient rooms, lockers, and drawers to detect contraband to ensure a substance-free safe environment.[77] VHA also requires that MH RRTP patients "…be randomly tested upon return from passes and health and welfare inspections of the Veteran's belongings at admission and random inspections of the Veteran's belongings upon return from pass."[78] We could not confirm that random testing and/or health and welfare inspections occurred after a pass due to the absence of documentation for the patients we reviewed.

During the initial phase of substance abuse treatment, patients are vulnerable to relapse due to the complexity of the ongoing addiction recovery process.[79] VHA Handbook 1160.04 requires a "24 hour a day 7 day a week structured and supportive residential environment as a part of SUD rehabilitative treatment before full community re-entry."[80] Issuing passes to patients recently admitted to the program who have not developed improved coping skills may increase the vulnerability to relapse.

We confirmed that MH RRTP staff provided patients in the SAR program passes during the initial phase of treatment. The MH RRTP treatment team permitted patients to leave the MH RRTP building with a restriction to remain on the facility grounds. Facility staff did not monitor compliance with patients staying on facility grounds, did not consistently maintain sign in and out sheets, and relied on patient self-adherence.

We requested documentation of the required 10 percent weekly contraband checks for the 12 months prior to our February visit. Facility staff informed us that contraband checks were not done consistently prior to January 2016. Management retrained the staff and implemented the checks starting in January 2016. Facility staff were unable to

[76] VHA Handbook 1162.02. Mental Health Residential Rehabilitation Treatment Program (MH RRTP), December 22, 2010.
[77] Ibid.
[78] Ibid
[79] http://www.crchealth.com/find-a-treatment-center/washington-treatment-information/5-stages-addiction-recovery/.
[80] VHA Handbook 1160.04. *VHA Programs for Veterans with Substance Use Disorders (SUD),* March 7, 2012. This VHA Handbook was scheduled to be recertified on or before the last working day of March 2017 and has not yet been updated.

provide complete documentation of the required 10 percent weekly contraband checks for January 2016 through February 2016.

In August, we requested and reviewed contraband logs for the required 10 percent weekly contraband checks. We were unable to decipher staff signatures or interpret coding and legends, which varied and were incomplete. We requested assistance from MH RRTP leadership to clarify the signatures and coding/legends; after multiple requests, leadership provided some clarifications.

In December 2016, the MH RRTP program manager signed a standard operating procedure (SOP) outlining the process for contraband checks. This SOP formalized the process that MH RRTP managers described in August. We found that the MH RRTP staff did not complete the 20 percent weekly contraband checks required by the facility's new SOP nor did they meet the VHA requirement of 10 percent weekly contraband checks.

Allegation 2: Inadequate MH RRTP Staffing

24 Hours a Day/7 Days a Week Staffing

We substantiated MH RRTP programs were inadequately staffed; staff were assigned to multiple units and did not perform all assigned duties (for example security checks). VHA identifies the minimal number of staff required to monitor each unit 24 hours a day/7 days a week.[81] VA Office of Mental Health Services staff confirmed and facility leaders agreed that 30 staff were needed to meet these requirements.[82,83]

The MH RRTP 24 hours a day/7 days a week staffing plan called for 24 DAs and 6 LPNs. According to a March 2016 communication with the facility, they planned to hire and recruit a sufficient number of staff to meet the VA Office of Mental Health Services recommendation. Facility leadership was aware for more than a year of a DA staff shortage but could not tell us how long.

MH leadership reported recruiting barriers for filling the DA positions including updating position descriptions, reclassifying DA position descriptions to social service assistant positions,[84] and negotiations with the union regarding the change in the position descriptions. An MH RRTP manager told us that to manage 24 hours a day/7 days a week staff shortages, leadership provided overtime opportunities for all MH RRTP staff (such as program staff assistants, DAs, LPNs, and nurse's aides) to perform DA duties.

[81] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
[82] The VA Office of Mental Health provides national direction for multiple mental health areas including residential rehabilitation programs. http://vaww.mentalhealth.va.gov/omhs-home.asp. Accessed February 15, 2017.
[83] VHA Handbook 1162.02.
[84] Domiciliary Assistants (DA) position classifications were re-classified as Social Service Assistants. The term DA is used in this report.

During our February evaluation of daily security checklists and CCTV tapes, we confirmed that the units were not always adequately staffed.[85] We determined that staff members were assigned to multiple units 39 percent of the time, which is out of compliance with VHA guidelines.[86]

During the August site visit, we confirmed through interviews that two MH RRTP DAs were hired and interviews were being conducted for additional 24 hours a day/7 days a week staff. In February 2017, we determined that MH leadership made progress towards fulfilling the staffing guidelines.

During our August evaluation, we reviewed daily security checklists and the CCTV tapes and confirmed that the units were not always adequately staffed. When comparing our reviews, from February and August 2016, we found an 18 percent increase in staff assigned to individual units.

Dedicated Psychiatrist

We confirmed facility leaders had not assigned a dedicated psychiatrist to the MH RRTP. Patients required a pass to leave the MH RRTP building to attend psychiatrist appointments in the MH outpatient clinic for medication prescribing and monitoring. As noted above, staff did not consistently monitor patients returning from pass or perform contraband checks.

Facility leadership acknowledged the importance of psychiatrists physically located on the unit and being a member of the MH RRTP interdisciplinary team. We confirmed that facility leadership had either re-assigned or hired psychiatrists to be physically located on the unit as of September 26, 2016.

Allegation 3: A Physician Prescribed A MH RRTP Patient a Higher than Indicated Buprenorphine/Naloxone Dose

We did not substantiate that a patient (Patient 1) was given a higher than indicated buprenorphine/naloxone dose. Prior to admission to the MH RRTP SAR program the patient was admitted to the AMHIU where he received buprenorphine/naloxone. While he was on the AMHIU, MH providers monitored him for common signs and symptoms of opiate withdrawal using the COWS.[87]

The patient's provider prescribed a dosage of buprenorphine/naloxone, which was within suggested ranges for his phase of treatment, when he transitioned from the

[85] VHA Handbook 1162.02. *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
[86] Ibid.
[87] The COWS is an evidence-based tool developed by the National Alliance of Advocates for Buprenorphine Treatment and administered by a clinician to monitor the common signs and symptoms of opiate withdrawal.

AMHIU to the MH RRTP SAR.[88] His MH RRTP SAR medication regimen consisted of daily medications and as needed medications. We found no contraindications with his prescribed medications and buprenorphine/naloxone. Both the buprenorphine/naloxone dosage when in AMHIU and MH RRTP were within recommended ranges.[89]

The patient was not feeling well and an MH RRTP RN evaluated the patient three times over 3 days. The RN documented in the EHR that she sent the patient to the ED, but later clarified that the patient declined to go the ED.

On the day of his death, the patient's routine daily medication regimen consisted of the medications prescribed by the provider.

MH RRTP staff had conducted UDTs as required by VHA to detect illicit drug use (all results were negative) while the patient was taking buprenorphine/naloxone as recommended by SAMSHA guidelines,[90] and nursing staff notified the case manager when the patient did not show up during regular medication administration hours. The autopsy toxicology results indicated that the patient did not have the prescribed buprenorphine/naloxone in his system. The facility MH RRTP manager stated he did not have contraband checks documented prior to January 2016.

Allegation 4: The AMHIU is Not Safe and Secure

Based on an incident involving a visitor providing a patient contraband, we focused our review of safety and security on the AMHIU visitation procedures including contraband checks.

We substantiated that in spring 2016, staff were not consistently checking visitors for contraband. Patient 2 was found unresponsive in his room due to an overdose on the AMHIU after having visitors who were not checked for contraband. In accordance with VHA Handbook guidelines, staff notified the VA Police who investigated the incident.[91] Facility leadership revised visitation procedures on the AMHIU and in July 2016 issued a Visitation SOP outlining checks for hazardous items upon admission and during hospitalization.[92]

We reviewed the August 2016 AMHIU CCTV tapes for selected times and observed that visitors placed personal items in sally port visitor lockers, patients had no more than two visitors at a time, visitors in view of the camera remained in the designated visitor area, and children did not visit patients. However, we had limited views due to the angle of the cameras and were unable to determine whether visitors checked into the unit office

[88] Center for Substance Abuse Treatment. *Clinical Guidelines for the Use of Buprenorphine in the Treatment of Opioid Addiction*. Treatment Improvement Protocol(TIP) Series 40. DHHS Publication No. (SMA) 04-3939. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2004.
[89] Ibid.
[90] Ibid.
[91] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.
[92] Standard Operating Procedure Mental Health Division: Acute Mental Health, *Visitation*, July 2016.

upon entering and exiting the unit, all visitors remained in designated visitor areas, or staff inspected packages brought onto the unit or noted items on an inventory sheet prior to giving them to a patient.

Facility managers have taken reasonable measures to improve the safety and security of the AMHIU in regards to contraband/hazardous items checks. As of February 2017, a MH leader reported no new incidents of hazardous items on the unit.

Allegation 5: Management and Operations in the MH RRTP

Failure to Conduct Random Contraband Checks Led to an Attempted Suicide and a Patient Having a Syringe in his Room**.**

We could not substantiate that a failure to conduct random contraband checks led to unsafe conditions for two patients. The facility identified and we reviewed two patients whose circumstances matched a patient attempted suicide (Patient 3) and a patient with a syringe on the unit (Patient 4) described above.

Patient 3 was on self-medication Level III and therefore could keep his medications in his room. Staff documented in the EHR that the patient said he had intentionally taken several of his pills. Staff conducted a contraband check within an hour after the reported overdose that did not reveal contraband or potentially dangerous items. The patient's laboratory results and physical examination did not support severe symptoms related to an overdose. He was medically cleared from the ED for admission to the AMHIU within 7 hours of the reported overdose. We could not determine if a contraband check would have made a difference as the patient was on the Level III program allowing medications to be kept in his room.

Patient 4 was sent to the ED three times and after the second visit was found to have syringe and other contraband items. With the first ED visit, the patient was prescribed pain medication and was discharged from the ED to walk back to the MH RRTP unescorted. Providers' documentation in the ED EHR did not reference alcohol use.

Upon return to the MH RRTP, staff suspected the patient of alcohol use. He tested positive for alcohol with a breathalyzer. The patient was escorted to the ED for medical clearance. He was escorted back to the MH RRTP after he was medically cleared and staff performed a contraband check in the patient's room and discovered a syringe and other contraband items. MH RRTP staff found 45 prescription medications in his pocket and VA Police escorted the patient back to the ED. The third ED visit was less than an hour later and the patient was admitted to AMHIU. The patient left AMA in less than a day.

While staff found contraband during a contraband check, which was appropriate, we found lapses in his care. We found that the patient received a pain medication and when he was discharged from the ED; he walked back to the MH RRTP unescorted. Additionally, a random contraband check of his belongings was not documented when the patient entered the MH RRTP building, although, staff suspected alcohol use.

We could not determine if a contraband check after ED visit one would have made a difference because we do not know when he acquired the syringe.

An AIB Determined That the Domiciliary was not Safe and Secure.

We substantiated that an AIB was conducted and board members issued 16 recommendations. One of the recommendations addressed enhancing safety and security in the MH RRTP including police presence, conducting rounds, and adding card readers. In August 2016, we found increased police presence including a drug-sniffing dog and a newly hired private security guard on site during late night hours. Leadership added card readers to the entrances of the MH RRTP building; however, we found inconsistent rounds as discussed above.

Alleged Denial of Admission to MH RRTP SAR and Subsequent Suicide.

We did not substantiate that a patient (Patient 5) was denied admission to the MH RRTP SAR. We found the patient was discharged from the MH RRTP due to his failure to comply with policies. As noted above in the Patient 5 case summary, he was admitted to the MH RRTP. The interdisciplinary team talked with him on multiple occasions about inconsistent therapy attendance and other concerns. MH RRTP staff initiated the discharge. Before discharge, MH RRTP staff overheard the patient on the telephone making suicidal threats and staff called the VA police to escort him to the ED. After a brief stay in the ED and an acute medical unit, the patient was transferred back to MH RRTP and discharged.

VHA Handbook 1162.02 states, "[t]here are circumstances when the interdisciplinary team may take unilateral action to discharge a Veteran prior to program completion. These circumstances include:

(a) Dangerous behavior;

(b) A relapse or unauthorized use of an addictive substance; and

(c) A pattern of "lack of engagement" in treatment services."[93]

According to the discharge summary in the EHR, the MH RRTP discharge was completed when the patient failed to comply with certain staff requests and program policies. We determined discharge from the MH RRTP program was within the provider's clinical judgement and guidelines; however, we noted deficiencies by MH providers who are to oversee care.

The patient had a PRF and completed suicide within 2 days of discharge from a medicine unit and the MH RRTP. Upon our review of the EHR, we determined an MHTC was not identified and the SPC was not notified about the discharge. The patient attempted to reach an outpatient MH clinician late in the day before his death and the

[93]VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP),* December 22, 2010.

nurse that answered the call added MH providers and the SPCs as signers to the note. The first attempt to call him back was after his death.

6: Additional Issues

MHTCs

We found an MHTC was not identified in Patient 5's EHR. Of the seven patients we reviewed, we were unable to find documentation in the EHRs that MHTCs were identified. We requested verification from facility managers who were able to identify one of the seven patients whose MHTC had been identified.

MH Aftercare

During the August unannounced visit, staff expressed concerns about lack of or minimal aftercare resulting in readmissions.

VHA Handbook 1160.01[94] states that "[f]acilities must ensure that discharge planning, including an aftercare plan, occurs for all Veterans leaving an MH RRTP and that these Veterans are provided services based on a plan of care addressing clinical needs at time of discharge."

We reviewed aftercare program schedules and determined aftercare was available during day, evening, and weekend hours. Additionally, we evaluated whether or not patients were offered aftercare services while conducting the above patients' EHR review summaries. We validated that six of the reviewed patients who required post discharge follow-up care appointments received appointments; however, not all of the patients attended the appointments. However, some of the patients did not attend their scheduled aftercare appointments nor could they be reached when staff attempted to contact them for post discharge follow-up care.

Patient Safety Concerns

After our August site visit, we were given the names of two additional patients with potential safety deficiencies. We reviewed both patients' EHRs and found that the facility staff rendered appropriate clinical care as described in the review summaries of Patients 6 and 7 above.

Conclusions

After our first site visit in February 2016, we noted the facility made some progress in addressing the MH RRTP safety concerns. However, on our second site visit in August 2016, we found continued unresolved concerns in multiple aspects of the MH

[94] VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008, amended November 16, 2015.

RRTP program. MH RRTP staff were not consistently conducting or documenting rounds; maintaining physical presence and engagement in the milieu on the units; or conducting contraband checks as required by VHA.

We substantiated that MH RRTP staff were not consistently monitoring access to the units. The visitor desk serves as a single point of access but was not manned by staff 24 hours a day/7 days a week during our first visit. We found on our second visit, that the entrance had been secured with a card key access door; however; staff did not consistently require visitors to sign in and out or ask them to identify themselves when entering the unit. We were granted access to the building without identifying ourselves, being checked for contraband, or asked to sign in. With the exception of Unit A, we found unsecured doors and unrestricted access to each unit.

We substantiated that MH RRTP staff were not consistently conducting or documenting rounds as required by VHA. We reviewed daily security checklists and CCTV tapes provided by facility staff. We found in both the February and August reviews that facility staff documented rounds numerous times throughout their shifts. However, according to times on the CCTV tapes, staff did not conduct rounds consistent with written documentation. The MH RRTP rounds are intended to reinforce the safety and security of patients, staff, and visitors.

We substantiated that MH RRTP staff were not consistently maintaining physical presence and engagement in the milieu on the units. At the time of our February 2016 unannounced site visit, we observed staff on Unit A. We did not observe staff on Units B, C, and D. We observed some staff on Unit E (common area and some staff offices) who interacted with patients. The CCTV tapes we reviewed after the August visit covered time frames while we were not onsite and showed staff inconsistently interacting with patients on Units C, D, and E when staff conducted periodic rounds. However, we did not observe interactions of staff with the patients on Unit B. We compared the schedules with CCTV tapes and we confirmed that the employees listed on the work schedules were on the units.

We substantiated that MH RRTP staff were not consistently conducting contraband checks as required by VHA. The MH RRTP treatment team permitted patients to leave the MH RRTP building with restriction to remain on the facility grounds. Facility staff did not monitor compliance with patients staying on facility grounds, did not consistently maintain sign in and out sheets, and relied on patient self-adherence. During our February 2016 visit, facility staff informed us that the required 10 percent weekly contraband checks were not done consistently prior to January 2016. In August 2016, we reviewed the weekly contraband checklists and were unable to decipher staff signatures, or interpret coding and legends, which varied and were incomplete. We found that the required 10 percent weekly contraband checks had not been completed. In December 2016, we found that the MH RRTP staff did not complete the 20 percent weekly contraband checks required by the facility's new SOP nor did they meet the VHA requirement of 10 percent weekly contraband checks.

We substantiated MH RRTP programs were inadequately staffed, staff were assigned to multiple units, and did not perform all assigned duties (for example security checks). For the facility, VA Office of Mental Health Services staff recommended, and facility leaders agreed, that 30 staff were needed to monitor each unit 24 hours a day/7 days a week. The MH RRTP 24 hours a day/7 days a week staffing plan called for 24 DAs and 6 LPNs. According to a March 2016 communication with OIG, facility leaders planned to hire and recruit a sufficient number of staff to meet the VA Office of Mental Health Services recommendation. Facility leaders were aware for more than a year of a DA staff shortage but could not tell us how long. During our February evaluation of daily security checklists and CCTV tapes, we determined that staff members were assigned to multiple units 39 percent of the time. When comparing our reviews from February and August 2016, although we found an 18 percent increase in staff assigned to individual units as required, units were still not staffed as VHA requires. Additionally, we confirmed facility leaders had not assigned a dedicated psychiatrist to the MH RRTP. Facility leadership acknowledged the importance of psychiatrists being physically located on the unit and being a member of the MH RRTP interdisciplinary team, and we confirmed that as of September 2016, psychiatrists allocated portions of their time to be physically present on the unit.

We did not substantiate that a patient was given a higher than indicated dosage of buprenorphine/naloxone. The patient's provider prescribed a dosage of buprenorphine/naloxone that was within clinical guidelines for his phase of treatment when he transitioned from the AMHIU to the MH RRTP SAR. The patient was found dead after returning from a pass with no documentation to support that a contraband check had been completed on his return. The autopsy report attributed the cause of death as acute mixed drug toxicity, and classified the manner of death as accidental. Toxicology results indicated that the patient did not have buprenorphine/naloxone in his system.

Based on an incident involving a visitor providing a patient contraband, we focused our review of the safety and security on the AMHIU visitation procedures including contraband checks. We substantiated that in 2016, staff were not consistently checking AMHIU visitors for contraband. A patient was found unresponsive in his room due to a drug overdose after having visitors who were not checked for contraband. In accordance with VHA Handbook guidelines, staff notified the VA Police who investigated the incident, facility leadership initiated an RCA, and managers issued a visitation SOP. Facility managers have taken reasonable measures to improve the safety and security of the AMHIU in regards to contraband/hazardous items checks. As of February 2017, an MH leader reported no hazardous items found on the unit.

We could not determine that a failure to conduct random contraband checks led to an attempted suicide and a patient with a syringe in his room. The patient that allegedly attempted suicide was on a self-medication Level III and could keep his medications in his room; therefore, we could not determine if a contraband check would have made a difference. The patient who was found to have a syringe in his room was sent to the ED three times in an evening, and after the second visit was found to have a syringe and other contraband items. We could not determine if a contraband check after any of the

ED visits would have made a difference because we do not know when he acquired the contraband.

We substantiated that an AIB was conducted and board members issued 16 recommendations. One of the recommendations addressed enhancing safety and security in the MH RRTP. In August 2016, we found increased police presence including a drug-sniffing dog and a newly hired private security guard on site during late night hours. Facility leaders added key card readers to the entrances of the MH RRTP building; however, we found rounds were inconsistently implemented for safety and security processes, and we were allowed into the building without being asked to identify ourselves or checked for contraband.

We did not substantiate that a patient was denied admission to the MH RRTP. We found the patient was discharged from the program due to his failure to comply with policies. We determined discharge was within the provider's clinical judgement and program guidelines. However, we noted deficiencies by MH providers who are to oversee care. Upon our review of the patient's EHR, we determined an MHTC was not identified, and the SPC was not notified about the discharge. Of the seven patients we reviewed, we were unable to find documentation in the EHRs that MHTCs were identified. We requested verification from facility managers who were able to identify one of the seven patients whose MHTC had been identified.

We determined facility aftercare programs were available during day, evening, and weekend hours. We validated that six of the reviewed patients who required post discharge follow up care appointments, received appointments; however, not all of the patients attended the appointments.

In two of the seven patients we reviewed, those who were identified after our second visit as possibly receiving inadequate care in the MH RRTP, we found facility staff followed clinical care guidelines for both patients.

Recommendations

1. We recommended that the Facility Director ensure that Mental Health Residential Rehabilitation Treatment Program local policies are consistent with the Veterans Health Administration Mental Health Residential Rehabilitation Treatment Program Handbook and Mental Health Residential Treatment Program leaders and staff adhere to the policies.

2. We recommended that the Facility Director ensure that the Mental Health Residential Rehabilitation Treatment Program managers monitor compliance as outlined by Veterans Health Administration Mental Health Residential Rehabilitation Treatment Program Handbook.

3. We recommended that the Facility Director ensure that the Mental Health Residential Rehabilitation Treatment Program has adequate resources, including staff, as specified by the Mental Health Residential Rehabilitation Treatment Program Handbook to provide a safe therapeutic environment.

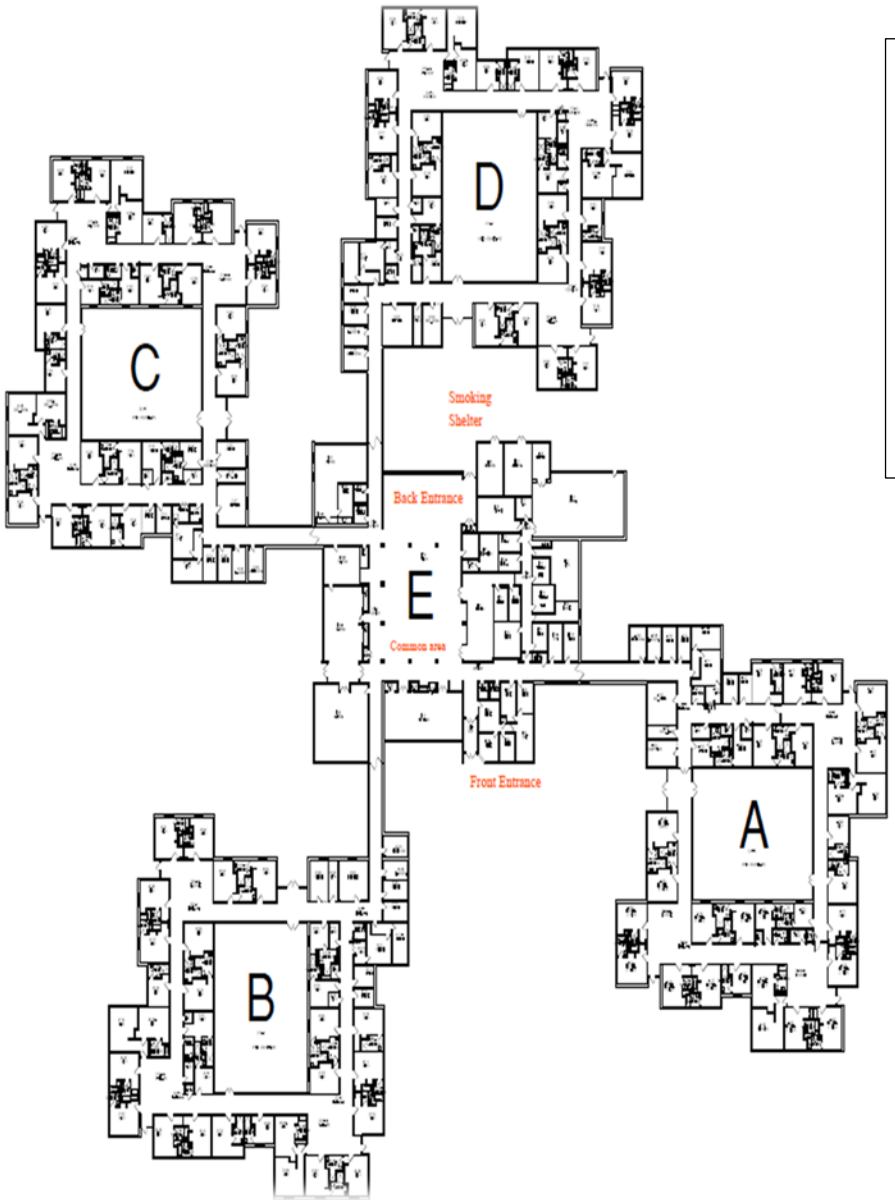
4. We recommended that the Facility Director ensure full implementation of the Acute Mental Health Inpatient Unit visitation policy and monitor for compliance.

5. We recommended that the Facility Director implement assignments of Mental Health Treatment Coordinators to mental health patients and strategies to enhance communication and coordination across mental health clinical areas.

Appendix A

Facility MH RRTP Building Diagram

MH RRRTP Building 123



Main campus building with access to the rest of the main buildings through connecting corridors.

Programs

Unit A	Women Veterans and Hoptel beds
Unit B	Domiciliary Care for Homeless Veterans: Intensive Acceptance and Commitment Therapy: General Mental Health: Operation Enduring Freedom/Operation Iraqi Freedom/ Operation New Dawn
Unit C	General Mental Health; Post-Traumatic Stress Disorder; Substance Abuse Rehabilitation
Unit D	Substance Abuse Rehabilitation

Source: Facility

Appendix B

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: June 9, 2017

From: Director, Great Lakes Health Care System (10N12)

Subj: Healthcare Inspection— Management of Mental Health Care Concerns, Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin

To: Director, Dallas Office of Healthcare Inspections (54DA)
Director, Management Review Service (10E1D MRS Action)

1. I have reviewed the draft report and concur with the response to the recommendations provided by Milwaukee VAMC.

Renee Oshinski

Renee Oshinski
Network Director, VISN 12

Appendix C

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: June 6, 2017

From: Director, Clement J. Zablocki VA Medical Center (695/00)

Subj: Healthcare Inspection— Management of Mental Health Care Concerns, Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin

To: Director, Great Lakes Health Care System (10N12)

1. I have reviewed the draft report of the Office of Inspector General's review of the Mental Health Residential Rehabilitation Treatment Program and Acute Mental Health Inpatient Unit at the Clement J. Zablocki VA Medical Center. We concur with all recommendations.

2. Please see the attached response to the recommendations identified in the review.

3. I appreciate the opportunity for this review as a continuing process to improve care to our Veterans.

Daniel S. Zomchek, Ph.D., FACHE
Medical Center Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Facility Director ensure that Mental Health Residential Rehabilitation Treatment Program local policies are consistent with the Veterans Health Administration Mental Health Residential Rehabilitation Treatment Program Handbook and Mental Health Residential Treatment Program leaders and staff adhere to the policies.

Concur

Target date for completion: November 1, 2017

Facility response: All local MHRRTP policies were updated to be consistent with national policy and the VHA MHRRTP Handbook. Information received through consultation with the Office of Mental Health Operations (OMHO), the VISN 12 Mental Health Lead, and two experienced VA MHRRTP managers who were detailed to the program was assistive in creating new or updating current local MHRRTP policies. The updates and new local policies were completed and communicated to all staff by May 12, 2017.

Monitoring adherence to these policies is currently underway and is targeted to be completed by November 1, 2017.

Recommendation 2. We recommended that the Facility Director ensure that the Mental Health Residential Rehabilitation Treatment Program managers monitor compliance as outlined by Veterans Health Administration Mental Health Residential Rehabilitation Treatment Program Handbook.

Concur

Target date for completion: November 1, 2017

Facility response: The medical center developed an action plan that addresses areas in need of improvement in the MHRRTP, incorporating requirements from the VHA MHRRTP Handbook and an OMHO MHRRTP site visit in August 2016. The plan addresses staffing, security, safety, rounding, and programing. The process to develop, implement, and complete the actions on the plan included weekly meetings with facility senior leadership, MHRRTP management, Mental Health leadership, VISN MH leadership, and monthly consultation calls with VHA OMHO MHRRTP leadership.

The medical center will monitor compliance with a target date for completion by November 1, 2017.

Recommendation 3. We recommended that the Facility Director ensure that the Mental Health Residential Rehabilitation Treatment Program has adequate resources, including staff, as specified by the Mental Health Residential Rehabilitation Treatment Program Handbook to provide a safe therapeutic environment.

Concur

Target date for completion: Completed

Facility response: The medical center invested in additional resources as required for the MHRRTP, including staffing, per the MHRRTP Handbook. As of February 6, 2017, the approved staffing met the MHRRTP Handbook requirements. In a May 2017 follow-up review by VHA OMHO, surveyors verbally confirmed adherence to required staffing levels.

Recommendation 4. We recommended that the Facility Director ensure full implementation of the Acute Mental Health Inpatient Unit visitation policy and monitor for compliance.

Concur

Target date for completion: Completed

Facility Response: The AMHIU policy for visitation was updated and signed in August 2016. Staff was educated on the policy updates. The updated policy ensures that staff checks visitors into the unit, uses lockers for storage of any belongings brought into the unit by visitors, and that they are monitored via CCTV during visitation. Compliance with the policy was audited by AMHIU management and the program was found to be compliant with the visitation policy. Ongoing documentation reviews are conducted to assure continued compliance.

Recommendation 5. We recommended that the Facility Director implement assignments of Mental Health Treatment Coordinators to mental health patients and strategies to enhance communication and coordination across mental health clinical areas.

Concur

Target date for completion: 90 days from published final report

Facility response: In late 2016, VACO implemented a web-based version of the Patient Centered Management Module (PCMM). This included major changes during migration of the data, leading to hundreds of patient assignments becoming “unassigned” beyond our control. With that said, we have reviewed our current process and have reeducated our clinicians on the importance of the Mental Health Treatment Coordinators (MHTC) assignment and reassignment process. Clerical staff have been added to assist with the assignment and reassignment requests.

National reports developed to assist VA facilities with identifying Veterans who have been seen but not assigned a MHTC are now being utilized by staff to improve our process as well.

Compliance with this measure continues to be monitored. We will meet the national metric within 90 days of this report being published.

Appendix D

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Contributors	Rose Griggs, MSW, LCSW, Team Leader Shelia Farrington-Sherrod, MSN RN Gayle Karamanos, PA C Cathleen King, MHA, CRRN Julie Kroviak, MD Laurie Urias

Appendix E

Report Distribution

VA Distribution

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Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Great Lakes Health Care System (10N12)
Director, Clement J. Zablocki VA Medical Center, Milwaukee, Wisconsin

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U.S. Senate: Tammy Baldwin, Ron Johnson
U.S. House of Representatives: Sean P. Duffy, Mike Gallagher, Glenn Grothman, Ron Kind, Gwen Moore, Mark Pocan, Paul D. Ryan, F. James Sensenbrenner.

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