DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Supervision and Care of a Residential Treatment Program Patient at a Veterans Integrated Service Network 10 Medical Facility

HEALTHCARE INSPECTION | REPORT # 16-03137-208 | JULY 12, 2018

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate the 2016 overdose death of a patient in a residential treatment program (Program) at a Veterans Integrated Service Network medical facility (Facility).[1] The purpose of the inspection was to review the supervision and care of the patient while enrolled in the Program.

The Program is offered in a structured and supportive residential environment, 24 hours each day, seven days each week. Generally, Program patients reside in a building (Building 1) that provides residential level of care, which is supportive but has less medical availability than an inpatient unit within a hospital. Under certain circumstances, such as when medical care is needed in conjunction with the Program, a patient may be assigned to a unit in another building on Facility grounds (Building 2), which provides access to 24-hour medical care.

The OIG identified issues relating to the supervision of the patient who is the subject of this report (Program patient). Supervision issues involved

- Inconsistent Facility policy directions for patient check-ins,
- Staff compliance with Veterans Health Administration (VHA) and Facility policies/procedures regarding the management of patient check-ins and missing patients when they failed to check-in, and
- Random screening of patients for drugs and alcohol abuse.

The staff on Building 2 failed to consistently apply the Program workbook and other residential rehabilitation treatment programs' (RRTP) guidance such as the RRTP Manual, or the RRTP Handbook requirements for patient check-ins. The OIG found that Facility policy directions for check-ins in the three policies were different. Different policies may result in inconsistent application and confusion for patients and staff. On two occasions when the patient at issue did not check-in as required, staff did not follow the Facility policy for missing patients although the patient was considered to be at a higher risk of harm. The patient attended group meetings and participated in individual therapy two or three times per weekday during which staff observed and documented the patient's demeanor. On four occasions, the staff described the patient as having a different demeanor: drowsy, tired, and/or withdrawn. Though staff recorded these

[1] The name of the Facility is not being disclosed to protect the privacy rights of the subject of the report pursuant to 38 U.S.C. §7332, *Confidentiality of Certain Medical Records*, January 3, 2012.

changes, they did not perform additional testing for alcohol or other substances as required by VHA and Facility policy.

The OIG identified issues relating to the quality of care of the Program patient. Specifically, the OIG found that Program staff did not develop and implement a timely and comprehensive interdisciplinary treatment plan, provide services during the weekends, reassess the patient's restrictions, and submit timely and accurate documentation as required by VHA and Facility policies/procedures. OIG was unable to assess whether the impact of these failures directly affected the patient's outcome.

The OIG made five recommendations to the Facility Director:

- Ensure that Facility managers coordinate and implement uniform Program policies and procedures relating to supervision of patients, and that Facility staff consistently follow those policies and procedures.
- Ensure that the Mental Health Treatment Coordinator and interdisciplinary team develop and document the interdisciplinary treatment plan, as required by VHA and Facility policy.
- Ensure that the Program offers patient treatment, daily, as required by VHA.
- Ensure that the Program managers regularly evaluate restrictions to patient privileges and methods to reinstate restricted or lost patient privileges, as required by VHA.
- Ensure that Facility staff document Program patient care in the electronic health record within VHA and Facility requirements and timeframes.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 18-21 for the Directors' comments.) The OIG will follow up on the planned actions until they are completed.

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Contents

Abbreviations

CARF	Commission on Accreditation of Rehabilitation Facilities
DoD	Department of Defense
EHR	electronic health record
FY	fiscal year
IDTP	interdisciplinary treatment plan
MH	mental health
MH RRTP	mental health residential rehabilitation treatment program
MHTC	mental health treatment coordinator
OIG	Office of Inspector General
OT	occupational therapy
PTSD	post-traumatic stress disorder
RRTP	residential rehabilitation treatment program
SUD	substance use disorder
UDS	urine drug screen
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

Introduction

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to evaluate the 2016 overdose death of a patient in a residential treatment program (Program) at a Veterans Integrated Service Network 10 medical facility (Facility).[2] The purpose of the inspection was to review the supervision and care of the patient while enrolled in the Program.

Background

The Facility offers a wide range of inpatient, outpatient, and emergency care, including mental health services.

Post-Traumatic Stress Disorder

Some people may develop post-traumatic stress disorder (PTSD) after experiencing or witnessing a life-threatening event, such as combat, a natural disaster, a car accident, or sexual assault.[3] Symptoms include unwelcomed thoughts about the trauma, avoiding situations that are reminders of the trauma, negative thoughts and feelings such as sadness or loss of interest in things once enjoyed, and feeling on edge.[4] Some people with PTSD symptoms cope by drinking and/or using drugs.[5]

Substance Use Disorder

A substance use disorder (SUD) is diagnosed when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and

[2] The name of the Facility is not being disclosed to protect the privacy rights of the subject of the report pursuant to 38 U.S.C., Section 7332, Confidentiality of Certain Medical Records, January 3, 2012.

[3] VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, revised December 8, 2015. This handbook was rescinded and replaced by VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, November 16, 2017.

[4] U.S. Department of Veterans Affairs National Center for PTSD, *Understanding PTSD and PTSD Treatment,* https://www.ptsd.va.gov/public/understanding_ptsd/booklet.pdf. (The website was accessed on June 2, 2017.)

[5] U.S. Department of Veterans Affairs National Center for PTSD (2015), *PTSD and Substance Abuse in Veterans*, https://www.ptsd.va.gov/public/problems/ptsd_substance_abuse_veterans.asp. (The website was accessed on February 26, 2018.

failure to meet major responsibilities at work, school, or home.[6] According to VHA literature, more than 30 percent of veterans diagnosed with PTSD have an SUD.[7]

For PTSD patients with a co-occurring SUD, some VHA residential treatment programs provide integrated SUD treatment, which can be inpatient or outpatient. Integration can be obtained by providing SUD treatment within a PTSD program, PTSD treatment within an SUD program, or coordinating care between PTSD and SUD programs. Each VHA PTSD team has an SUD specialist assigned to it.[8]

Opioids—Heroin and Fentanyl

Opioids are a class of drugs that include prescription pain relievers such as oxycodone, hydrocodone, morphine, codeine, and fentanyl, as well as illicit drugs such as heroin.[9] In addition to relief of pain, opioids can produce feelings of extreme excitement and happiness, referred to as euphoria, as well as sleepiness and drowsiness. At high doses, opioids can cause respiratory depression and other physiological actions that can lead to death. This class of drugs is often misused by individuals to attain the euphoria effect.[10]

Heroin, processed from morphine, is an illegal and addictive opioid drug that may be snorted, smoked, or injected. Fentanyl, a synthetic morphine alternative, is 50 to 100 times more potent than morphine. Fentanyl may be mixed with the illegal drug heroin to produce increased euphoric results (with or without the user's knowledge).[11]

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[6] Substance Abuse and Mental Health Services Administration (SAMHSA), Mental and Substance Use Disorders. Substance Use Disorders. https://www.samhsa.gov/disorders/substance-use. (The website was accessed on February 26, 2018.)

[7] VHA Handbook 1160.03.

[8] U.S. Department of Veterans Affairs, Office of Patient Care Services–Office of Mental Health Services. (September 2010). *Fact Sheet: VA Services for Patients with Substance Use Disorders (SUD).* https://www.mentalhealth.va.gov/providers/sud/docs/Fact_Sheet_SUD_final_9-2010.pdf. (The website was accessed on June 29, 2017.)

[9] Opioids include the illegal drug heroin, as well as powerful pain relievers available legally by prescription, such as codeine, morphine, fentanyl, and many others. National Institute of Health, National Institute on Drug Abuse. Opioids, Opioid Overdose, *Opioid Basics, Fentanyl*. https://www.drugabuse.gov/drugs-abuse/opioids. (The website was accessed on May 16, 2017.)

10 National Institute on Drug Abuse. (August 2016), Misuse of Prescription Drugs. https://www.drugabuse.gov/publications/research-reports/misuse-prescription-drugs/which-classes-prescription-drugs-are-commonly-misused. (The website was accessed on March 18, 2016.)

[11] Centers for Disease Control and Prevention, *Opioid Overdose*, https://www.cdc.gov/drugoverdose/opioids/fentanyl.html; U.S. Department of Justice Drug Enforcement Administration, Diversion Control Division, Drug & Chemical Evaluation Section. *Fentanyl,* https://www.deadiversion.usdoj.gov/drug_chem_info/fentanyl.pdf. (The websites were accessed on June 3, 2017.)

In March 2015, the Drug Enforcement Agency issued a nationwide alert concerning the dangers of heroin laced with fentanyl.[12]

Veterans Health Administration Mental Health Residential Rehabilitation Treatment Programs

Veterans Health Administration (VHA) Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) provide clinical and supportive care to patients who have a wide range of problems, illnesses, or rehabilitative care[13] needs, which may include mental health and SUDs, co-occurring medical conditions, and psychosocial needs such as homelessness and unemployment. All MH RRTP models provide a therapeutic setting utilizing both professional and peer support, 24 hours each day, seven days each week.[14]

VHA's MH RRTP goal is to provide patients with opportunities to achieve and maintain their highest level of independent community integration. Consequently, MH RRTPs offer the least intensive level of VA inpatient care. MH RRTP patients do not require bedside nursing care that patients admitted to hospitals or nursing homes need, and are generally capable of self-care,[15] such as dressing, grooming, and eating.[16]

VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program*, establishes MH RRTP policy and procedures,[17] and requires MH RRTPs to be accredited by The Joint Commission and the Commission on Accreditation of Rehabilitation Facilities (CARF) in Behavioral Health and Residential Treatment standards for Behavioral Health Care (24-hour settings).[18] Specific to the patient circumstances described in this report, the Handbook provides the VHA patient supervision and care requirements for residential programs such as the Facility's Program. Each MH RRTP must be staffed by an interdisciplinary clinical team comprised of healthcare professionals trained to assess patients and provide interventions specific to the patient program. For example, PTSD patients should have services provided by

[12] U.S. Department of Justice Drug Enforcement Administration. (March 18, 2015), DEA Issues Nationwide Alert on Fentanyl as Threat to Health and Public Safety. https://www.dea.gov/divisions/hq/2015/hq031815.shtml. (The website was accessed on June 3, 2017.)

[13] Rehabilitation or rehabilitative care means providing services such as physical therapy, and mental health, to help a person regain lost of impaired abilities due to disease injury or treatment, https://www.cancer.gov/publications/dictionaries/cancer-terms?cdrid=775084. (The website was accessed on December 19, 2017.)

[14] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program,* December 22, 2010. This VHA Handbook was scheduled for recertification on or before the last working day of December 2015 and has not been updated.

[15] VHA Handbook 1162.02.

[16] VHA Handbook 1170.04, *Rehabilitation Continuum of Care*, December 30, 2014.

[17] VHA Handbook 1162.02.

[18] VHA Handbook 1162.02.

staff who are trained in psychosocial evaluation and rehabilitation as well as the care for co-occurring disorders.[19]

The Program

The Program discussed in this report is one of several MH RRTP residential care models.[20] Patients accepted into the Program are generally capable of performing self-care tasks such as bathing and dressing and do not have nursing care needs that would require admission to an acute inpatient or nursing home care setting. Care provided by Program staff is focused on rehabilitative services that include medical and psychiatric treatments. In the VA, programs similar to the one discussed in this report are provided in a structured and supportive community environment, usually in a designated building or unit.[21]

The Facility has designated beds for Program patients[22] in two locations—Building 1 or Building 2. Program patients in Building 1receive combined clinical treatment and case management services with access to medical and MH providers through appointments and meetings.[23]

The Building 2 unit is designed to treat patients who are admitted for inpatient care and/or into the Program. Patients in the Building 2 setting have access to medical and mental health providers on a 24-hour basis.[24] According to Building 2 staff, patients housed in Building 2 need more access to medical care than could be provided at the Building 1 location. Examples described were patients that have medical co-morbidities, or a patient who experiences PTSD flashbacks. Building 2 was also described as quieter with a more structured environment.

The Program is a voluntary[25] recovery treatment program offered to patients with specific MH diagnoses in a structured and supportive residential environment.[26] An admission committee reviews patient diagnoses and care needs. If accepted by the committee, the patient receives a treatment agreement/contract that provides information about the Program expectations and attends a class or meets with staff to ask questions and get a clear understanding of what is expected during admission to the Program. The Facility patient rights and responsibilities, and details of non-compliance regulations that will lead to premature discharge from the Program are

[19] VHA Handbook 1162.02.
[20] VHA Handbook 1162.02.
[21] VHA Handbook 1162.02.
[22] Facility Domiciliary Residential Rehabilitation Treatment Program, Program Manual, 2015.
[23] Facility Workbook
[24] Facility Workbook.
[25] Facility Program Manual.
[26] Facility Workbook.

reviewed, and the patient signs a statement of understanding.[27] The admission committee also decides where the patient would be located (Building 1 or 2).

Regardless of location, a Program patient receives several interdisciplinary treatment team assessments upon admission, including work habits and skills, psychosocial, spiritual, occupational therapy, nutritional, medical, and suicide prevention. A clinical case manager (called the Mental Health Treatment Coordinator or MHTC) is assigned for each patient.[28] During orientation to the Program, patients receive a Residential Treatment Program Workbook.[29] The Workbook includes information on check-in times and procedures, levels of accomplishments and restrictions, acceptable behaviors, behavioral issues that may generate a more stringent contractual arrangement, group dynamics, peer support and feedback, and discharge criteria.[30] Patients may also receive an RRTP Handbook when admitted to Building 2 (but not Building 1) that describes check-in procedures for the Building 2 unit as well as other information on patient rooms, meals, and medications.[31] The check-in procedures in the Workbook and RRTP Handbook are similar but do not match. The Program is voluntary for patients; therefore, a patient may decide at any time to leave and not return.[32]

Program patients are prohibited from using or possessing alcohol and non-prescribed drugs while participating in the program.[33] Drug and alcohol testing is a crucially important dimension to the effectiveness of treatment programs and adds structure and establishes limits that are critical aspects of helping patients regain self-control and self-respect.[34]

Request for Review

In a 2016 letter, a complainant wrote that the patient, who "struggled to cope with traumatic stress" and had a history of substance abuse treatment, obtained and fatally overdosed on controlled substances in 2016, while under the supervision and care of the Facility. The OIG conducted a healthcare inspection focusing on the supervision and care of the patient while enrolled in the Facility's Program.

[27] Facility Program Manual.
[28] Facility Program Manual.
[29] Facility Workbook.
[30] Facility Workbook.
[31] Facility Handbook, February 22, 2016.
[32] Facility Program Manual; Facility Workbook.
[33] VHA Handbook 1162.02.
[34] National Institute on Drug Abuse (2013), accessed July 10, 2017, *Laboratory Evaluation: Testing for Alcohol and Substance Use*, https://www.drugabuse.gov/sites/default/files/files/LaboratryEvaluation.pdf. (This website was accessed on July 10, 2017).

Scope and Methodology

The OIG initiated a criminal investigation in mid-2016; the OIG healthcare inspection team initiated its review on November 15, 2016. The OIG healthcare team conducted a site visit which included an unannounced physical inspection of the RRTP units.

The OIG reviewed the circumstances of the patient's care at the Facility in 2016 and relevant documents including

- VHA directives and handbooks,
- Facility policies, and protocols,
- The patient's EHR, autopsy, and toxicology test results,[35]
- The Joint Commission and Commission on Accreditation of Rehabilitation Facilities (CARF) standards, and
- The VA/DOD *Clinical Practice Guideline for the Management of Substance Use Disorders*.

In the absence of current VA or VHA policy, the OIG considered previous guidance to be in effect until superseded by an updated or recertified directive, handbook, or other policy document on the same or similar issue(s).

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

[35] A test to determine the type and approximate amount of legal and illegal drugs, usually a blood, or urine sample. https://medlineplus.gov/ency/article/003578.htm. (The website was accessed on March 8, 2018.)

Patient Case Summary

The patient, a combat veteran, was discharged from military service in 2015 with a medical history that included traumatic brain injury and multiple facial fractures that required surgery. The patient's MH history included panic attacks, anxiety, PTSD, alcohol and tobacco abuse, and depression. Psychosocial stressors included a pending divorce, discharge from the military, a parent's death, and the loss of a job. Medications for sleep, anxiety, and depression were prescribed.

Nine months after discharge, the patient was admitted to the Facility for alcohol detoxification and was offered SUD treatment, but declined. During a psychiatry appointment the next month, the patient reported feelings of anxiety, alcohol consumption, and intermittent cannabis (marijuana) use. One month later, the patient did not show for a scheduled MH appointment, and Facility staff's attempts to contact the patient were not successful.

A few weeks later, the patient presented to the Facility's Emergency Department following a suicide attempt with a firearm and alcohol use. The patient was admitted to the Facility's inpatient MH unit for safety, stabilization, and treatment, and discharged six days later. The patient then participated in the Facility's outpatient MH program for several weeks. In early 2016, after reporting continued alcohol use and easy access to loaded firearms, the patient's EHR was flagged[36] as high risk for suicide. It was about this time that the patient expressed interest in and received information on residential treatment programs.

Program Enrollment

After a review by the Facility MH Residential Admissions Committee, the patient was admitted to the Program in 2016 (Day 1). The patient was assigned to Building 2, due to possible medical needs (which included complicated withdrawal symptoms and suspected benzodiazepine use) and the high risk for suicide flag. On admission, the patient's breathalyzer[37] test and urine drug screen[38] (UDS) were negative. The patient received assessments for dietary needs, MH occupational therapy for socialization, and nursing care.

The physician (psychiatrist) saw the patient on Day 2 and did an assessment and preliminary plan, which included current medications (that staff would administer initially) and

[36] VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide,* July 18, 2008. The flag alerts VA staff that a patient is at high risk for suicide, and the presence of the flag should be considered when making treatment decisions. This VHA Directive expired July 31, 2013 and has not been updated.

[37] A breathalyzer is a device used to determine the blood alcohol content using a breath sample. https://www.merriam-webster.com/dictionary/Breathalyzer. (The website was accessed on September 8, 2017.)

[38] A UDS is a test used to detect the presence of illegal drugs and some prescription medications. U.S. National Library of Medicine: *Urine Drug Screen*. (The website was accessed on July 10, 2017.)

encouragement to attend support groups and maintain sobriety. On Day 3, the patient was assessed by the Facility chaplain, who determined that the patient had no specific spiritual needs.

The patient was started in a MH occupational therapy (OT) group on Day 1 (assessment) and a psychotherapy group on Day 2. The OT group met twice a week (weekdays only) and included outings as part of the socialization therapy goals; the psychotherapy group met one to three times per day (weekdays only) and was led by different psychologists or clinical social workers to address patients' sobriety and MH issues. During weekdays, the patient attended yoga classes one to two times per week, and started aquatic therapy on Day 17. The patient also met with a psychiatrist, clinical psychologist, or clinical social worker for individual therapy one to two times per week. Initially, from Day 1 through Day 10, psychiatric nurses gave the patient medications three times per day. After Day 10, the patient was allowed to self-medicate and nursing staff no longer documented daily interactions.

From Day 1 to Day 5, staff described the patient as attentive and alert as well as fully participating and responsive during group meetings, and interactive with staff and other domiciliary patients.

On Day 6, the patient's attending psychiatrist approved a pass[39] for the patient to go off Facility grounds for the day with a program volunteer. According to a psychiatric nursing note, the patient left at 9 a.m. and returned at 1:15 p.m. At 8:50 p.m., Building 2 staff noted that the patient had not been seen during staff hourly rounds at 4 p.m., 5 p.m., 6 p.m., or 7 p.m. The note also stated that two other Program patients (cohorts) were not seen for the same hourly rounds. The nurse located the patient through a call to one of the cohorts, and the patient and two cohorts returned to the unit. The patient had a steady gait and was in a congenial mood. The patient submitted to a breathalyzer test, which was positive, and a UDS that was sent to the laboratory for testing; the nurse notified the hospitalist and nursing supervisor. A physician examined the patient at 11:51 p.m., and documented that the patient stated he had walked to a "nearby bar to drink and had Marijuana." The physician wrote orders restricting the patient to the Building 2 unit until an assessment could be done by the treatment team the following Monday. The patient remained on the unit throughout Day 7, and staff described the patient as "cooperative" and "appropriate."

On Day 8, the patient met with staff to discuss the unauthorized absence and relapse with multiple substances. The results from the UDS were positive for alcohol and opioids. The patient was alert and attentive during the meeting and acknowledged responsibility; staff informed the patient about a continued restriction to the Building 2 unit (this restriction was part of the behavioral contract with staff to remain sober). The patient attended the required group and

[39] Passes in the context of this report are authorized (permitted by the provider or team) absences to leave the Facility for purposes other than treatment, which are based upon the patient's actions during the course of treatment or therapy. Passes to leave the Facility may be restricted due to disruptive behaviors during treatment, refusing drug testing, or unexcused absences from treatment.

therapy sessions from Day 8 through Day 11, and was described as alert, attentive, and engaged. However, on Day 11, the patient discussed being bored after the groups, and feeling "jailed" with social work staff. During this meeting, social work staff discussed the two-week pass restriction.

The patient continued to be alert and engaged during group sessions on Day 12, 15, and 16 (group therapies and individual psychotherapy sessions were not offered on Days 13 and 14; staff documented only one interaction with the patient on Day 14 with no description of demeanor). On Day 17, the MHTC observed the patient to be "attentive yet appeared drowsy" and "head down for part of the group." During sessions on Days 18 and 19, the patient was alert and actively participated during group sessions. Staff did not document interactions with the patient on Days 20 and 21(weekend days), but noted the patient was alert and attentive during group sessions on Days 22 and 23.

On Day 24, the patient did not present for an 8:00 a.m. appointment but did present to a 9:00 a.m. MH RRTP group therapy where the MHTC observed the patient to be "attentive during session, although appeared drowsy and indicated feeling tired." On Day 25, during an appointment, the MHTC found the patient to be "alert, oriented, and somewhat drowsy…feeling "down," however, denied feeling depressed and indicated being "tired." During group session that day, the social worker noted that the patient was quiet during group and somewhat disruptive during one of the group exercises. Later that day, the patient's psychiatrist noted that the patient reported having had "some suicidal ideas" the previous week. On Day 26, the patient submitted a weekly UDS which was positive for opioids (test was not released/confirmed until Day 30).[40] During group sessions on Day 26, the patient participated when asked but appeared withdrawn. When other patients discussed their plans for the weekend, the patient talked about being in the unit all weekend.

On Day 27 at 12:25 a.m., a nurse found the patient unresponsive in bed. The patient was resuscitated by the emergency response team and transferred to the Facility Medical Intensive Care Unit. Later, MH RRTP staff searched the patient's room and found a spoon, a capped syringe, which appeared to be empty, and a lighter[41] in the front pocket of the patient's pants, located by the bed, on the floor. VA police conducted a subsequent search of the patient's room and found a substance that tested positive for heroin.

[40] Initial results, released Day 28, were positive for opioids and confirmatory results, released Day 30, were positive for morphine.

[41] Items such as a syringe and spoon are considered equipment used to take or use heroin. U.S. Drug Enforcement Administration, *Get Smart About Drugs, Heroin*. https://www.getsmartaboutdrugs.gov/content/how-identify-drug-paraphernalia. (The website was accessed on July 10, 2017.)

The patient remained unconscious in the Medical Intensive Care Unit and died on Day 30. A medical examiner determined the cause of death was accidental, acute heroin and fentanyl[42] intoxication.

Inspection Results

Issue 1: Supervision of the Program Patient

The OIG identified issues concerning (a) inconsistent policy directions for patient check-ins (supervision and verification of a patient's physical presence), (b) staff compliance with VHA and Facility policies/procedures regarding the management of patient check-ins and missing patients when they failed to check-in, and (c) random screening of patients for drugs and alcohol abuse.

Policy Check-in Directions

The staff on Building 2 failed to consistently apply the Program workbook (which patients in the Program receive and follow upon admission to the Building 2 unit), the RRTP Manual, and the RRTP Handbook requirements for patient check-in. However, the OIG team found that Facility policy directions for check-ins in the Program workbook, the RRTP Manual, and the RRTP Handbook were different. In addition, staff did not follow the Facility policy for missing patients when the patient did not check-in as required.

Patient Check-in Management

VHA requires bed checks by staff at approximately 11:00 p.m. and 6:00 a.m. to verify the physical presence of each patient. Per Facility policy, staff may increase patient check-ins based on an assessment of the patient's high-risk behaviors or illness.[43] The Facility's Program Workbook instructs patients that they must sign in for three of the four check-in times (8:00 a.m., 12:00 p.m., 4:00 p.m., and 9:00 p.m.). The patient must return to the unit at 9:00 p.m. and remain on the floor until morning.[44] The RRTP Manual requires patients to sign in with staff between 6:00 a.m. and 7:30 a.m. during weekdays, 9:30 a.m. and 10:30 a.m. on weekends, and 9:30 p.m. every evening.[45] The RRTP Handbook (which was specific to Building 2) directs staff to be present for a roll call at 8:00 a.m. (all patients must be present) and check-in with a staff member between 11:00 a.m. and noon; 4:00 p.m. and 5:00 p.m.; and at 9:00 p.m.[46]

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[42] Fentanyl is a synthetic opioid painkiller that is similar to morphine but is 50 to 100 times more powerful, National Institute on Drug Abuse, (2016, June 6), *Fentanyl*. https://www.drugabuse.gov/drugs-abuse/fentanyl. (The website was accessed on May 30, 2017.)

[43] VHA Handbook 1162.02.

[44] Facility Workbook.

[45] Facility Program Manual.

[46] Facility RRTP Handbook.

According to Facility policy, patients who may harm themselves, such as patients at risk for suicide, are considered missing and at risk of harm when their location is unknown, and they have not been present to receive a scheduled medication, treatment, meal, or appointment, such as a check-in. When a patient is missing, unit staff (authorized by clinical administration, such as a nursing supervisor or unit manager) must first perform a preliminary search when the patient does not present for an appointed time (immediate); if the patient is not found, then the unit staff will notify the attending provider or provider on-call and, if the patient is at risk, the VA police.[47]

On Day 6, at approximately 7:00 p.m., a unit nurse noticed that the patient, who was identified in the EHR as being at high risk for suicide, had not been seen by staff since checking in from pass with a unit nurse at 1:15 p.m. The patient had been granted a pass from 9:00 a.m. to 4:00 p.m. to leave the grounds with a VHA program volunteer, but was due (according to the Program workbook and RRTP Manual) to check in with the staff at 4:00 p.m. The patient (as well as two cohorts) had been missing for approximately three hours before the nurse noticed and began a search. The unit nurse was able to locate the patient and two cohorts, who were off the unit, and they returned to the unit. However, after the patient checked in at 1:15 p.m. from the approved pass, the patient admitted to leaving the unit with the two cohorts without a pass (unauthorized absence from the unit). The patient also admitted going to a bar to drink and use/take drugs. The patient tested positive for alcohol and opioids.

In another incident, on Day 24, the EHR reflects that the patient did not present for an 8:00 a.m. appointment. No additional documentation that the patient was sought or located was found; however, according to Building 2 staff, they are not always alerted when a patient does not appear for an appointment outside of the unit. Staff later recorded that the patient did present for scheduled group therapy at 9 a.m. but appeared drowsy and tired.

The OIG found Facility policy directions for check-ins in the Program workbook, the RRTP Manual, and the RRTP Handbook were different, which may have led to inconsistent application and confusion for the patient and staff. In addition, on Day 6, staff did not realize the patient was missing for three hours and was designated a high risk for suicide. Had the staff been aware, staff would have been considered the patient missing and initiated an immediate search after not showing up for the 4:00 p.m. check-in.

Screening the Patient for Drugs and Alcohol Abuse

Staff failed to test the patient for drugs when they noticed a change in behavior/demeanor that could have been indicative of drug use.

VHA and Facility policy require that toxicology tests, such as a UDS, be conducted at least weekly, at random, upon return from passes, and any time a patient is suspected of drug use.[48][49]

[47] Facility policy.
[48] VHA Handbook 1162.02.

Staff conducted a UDS every five days (with the exception of testing on Day 6, the day of an unauthorized absence and Day 7, the day after the unauthorized absence) during the patient's enrollment. However, approximately two weeks into the patient's Program enrollment, on Days 17, 24, 25, and 26, EHR documentation revealed changes in the patient's behavior, including being drowsy, tired, and/or withdrawn. The OIG team determined these signs to be an unusual presentation for the patient, compared to previous EHR notes, and could have been indicative of drug use. However, the OIG team found no evidence that the patient was tested for drug use other than the weekly UDS. The weekly UDS done on Day 26 was positive for opioids. The Day 26 test results, however, were not released until Day 30.

The OIG determined that the failure to test the patient after changes in demeanor decreased staff's ability to monitor the patient for suspected drug use (in addition to admitted use on Day 6) and to intervene accordingly depending on drug testing results.

Issue 2: Quality of Care

The OIG identified issues relating to the care of the Program patient. Specifically, the OIG found that Program staff (a) did not develop and implement a timely and comprehensive interdisciplinary treatment plan (IDTP), (b) provide services during the weekends, (c) reassess the patient's restrictions, and (d) submit timely and accurate documentation as required by VHA and Facility policies/procedures.

Interdisciplinary Treatment Plan

Program staff did not develop and implement a timely and comprehensive IDTP as required by VHA and Facility policy/procedure.

Facilities set timeframes for the completion of initial assessments and IDTPs.[50] The MHTC (along with team members) completes the IDTP within seven days of admission[51] and incorporates the patient as a full partner in the planning process.[52] The IDTP includes measureable goals, identified strengths, needs, abilities, preferences, barriers to care, cultural background, and patient limitations.[53] The IDTP must include specific goals, measurable objectives, and a designated person for addressing each goal.[54]

[49] Facility contraband protocol.
[50] The Joint Commission E-dition. Behavioral Health Standards. Care, CTS.02.01.03, March 11, 2018.
[51] Facility RRTP Manual.
[52] VHA Handbook 1162.02.
[53] Facility policy.
[54] VHA Handbook 1162.02.

The Joint Commission, one of VHA's accrediting bodies, requires decisions to be collaborative within the team when more than one service is involved in the patient's care[55] and that activity therapies used to support goals, such as supervised outings, are incorporated into the plan of care, treatment, and services.[56] Goals discussed in the plan should be expressed in a way that measures progress. Reasons for deferring goals should be documented.[57] Facility policy requires documentation of the patient's concurrence with the plan and the signature of each discipline providing psychiatric or substance abuse care.[58] [59] All team members electronically sign the IDTP to demonstrate knowledge of the plan, including changes and revisions.[60] [61] CARF-accredited programs must obtain the patient's signature and give the patient a copy of the plan.[62]

The IDTP for the patient at issue was started on Day 3, but was not completed and documented in the EHR (available to staff) until Day 9, eight days after the patient was admitted for treatment. The MHTC updated the plan, with effective dates of Days 15 and 29 but the updates were not completed and documented in the patient's EHR until Day 36 (six days after the patient's death).

Upon review of the initial IDTP and subsequent updates, the OIG team found that, though the program was providing supervised outings and group occupational therapy, the plan did not reference those specific interventions or their purpose and goals. Aquatic therapy was added on Day 17, but the plan did not reflect the addition of this intervention or the purpose or goals. The patient received psychiatric and substance abuse care from a psychiatrist, a social worker, and through group interactions led by an occupational therapist, a clinical psychologist, a graduate psychologist or a social worker. However, though these team members/services were listed as members of the team on the initial plan and updates, only the social worker (who wrote the plan) electronically signed the plan and updates. EHR documentation did not reflect that the team members participated, collaborated, and received notice of the IDTP. The IDTP indicated the patient agreed with the treatment plan, however, documentation did not include evidence of the patient's receipt of the plan.

[55] The Joint Commission E-dition. Behavioral Health Standards. Care. CTS.02.01.03 and CTS.03.01.01. January 1, 2018.

[56] The Joint Commission E-dition. Behavioral Health Standards. CTS.4.01.01, CTS.04.01.03 and CTS.04.03.17. January 1, 2018.

[57] The Joint Commission E-dition. Behavioral Health Standards. CTS.03.01.03. January 1, 2018.

[58] Facility policy.

[59] Facility Program Manual.

[60] Facility Program Manual.

[61] Facility Program Manual.

[62] Facility policy.

Program staff planned to initiate a Prolonged Exposure Therapy treatment;[63] however, documentation indicated that the therapy had been delayed with no specific reason for the delay in the plan (a note indicated the therapy was starting later than initially planned). In addition, contrary to the statement by the patient's MHTC that patients were not allowed passes during the first weekend of the program, and the subsequent restriction of passes on Day 11, the plan showed the patient had no restrictions and full privileges, which included passes.[64]

Provision of Treatment to the Patient

Program staff did not provide treatment or therapeutic activities to the patient on weekends (Saturdays and Sundays). VHA requires RRTP programs to provide a minimum of four hours per day of treatment or therapeutic activities, seven days per week.[65] Documentation did not include evidence that the patient received treatment or therapeutic activities as required during two of the three weekends. Nursing staff gave the patient medications from Day 1 through Day 10 (which can be considered treatment), but the patient self-medicated after that time. The patient had no interactions with the two therapy groups on any of the three weekends. A nursing note was entered on Day 14 to check on disability claims and where the patient would like to receive outpatient care when discharged; however, no medications were given. Nursing had no interactions documented with the patient on Days 13, 20, and 21. The patient admitted to staff that boredom was a trigger for substance abuse and, after the restriction to stay in the unit on Day 6, the patient complained on Day 7 of feeling bored and "jailed."

Patient Restrictions

Program staff did not reassess the restrictions imposed on the patient's privileges. CARF requires that Program staff implement written procedures governing the use of special treatment interventions, such as pass restrictions.[66] The OIG did not find evidence of a written process that included regular evaluation of restrictions to patient privileges or reinstatement of patient privileges.[67] For the patient at issue, OIG did not find documentation of discussion related to the Day 6 pass restriction.

Staff imposed restrictions on passes while the patient was in the Program. The patient was restricted to the unit on Day 6 for leaving the Facility without a pass. That restriction continued until, and after, a meeting between the patient and Program social worker on Day 11. During this

[63] Prolonged Exposure Therapy is used to decrease the patient's distress about the trauma that the patient has experienced. It involves education about the treatments and symptoms of PTSD, relaxation techniques, exposure to real-world situations and talking through the trauma.

[64] Facility Workbook.

[65] VHA Handbook 1162.02.

[66] Special treatment interventions include all interventions used for the patient, and may span the range from the type of therapy a patient receives to the loss of phone privileges. In this report, the special treatment intervention used were passes. CARF International, 2015 Behavioral Health Standards Manual, July 1, 2015–June 30, 2016.

[67] CARF International, 2015 Behavioral Health Standards Manual, July 1, 2015–June 30, 2016.

meeting, the social worker discussed a two-week restriction on passes to leave the unit with the patient and further stated that after the two weeks, the patient's "progress and safety" would be "evaluated for any potential need for further restrictions." Documentation did not reflect that the restriction was reviewed and/or discussed with the patient during or after the two weeks. The patient was found unresponsive in the early morning hours of Day 27. The IDTP, updated Day 15, incorrectly stated the patient had no restrictions and full privileges (which would have allowed passes).

Inaccurate and Late EHR Entries

VHA requires that that all EHR entries[68] be recorded and authenticated (process that ensures the entry has not been altered and must have date, time, and signature) immediately after the care event or observation to ensure that timely and accurate documentation is available. However, the individual facility may have specific time frames and requirements for entries that must also be followed.[69] Facility policy requires any type of progress note that denotes observations, progress, changes in treatment, response assessments, and pertinent findings, be written and signed in the computer at the time of the observation.[70] Late entries must be noted with the actual date the event/observation occurred, versus the date of documentation, and the reason for the delay.[71]The Facility quality management department monitors and reports to leadership when health records do not meet standards for accurate and timely documentation. [72]

In addition to the late EHR entries of the IDTP, lack of IDTP team member signatures, and inconsistent descriptions of the patient's restrictions, the occupational therapist did not enter eight of 11 signed progress notes in the EHR until after the patient's death. Though the notes in question had the dates of the event, they were signed by the occupational therapist approximately 17–28 days after the events; therefore, they were not entered in the patient's EHR until after the patient's death. The notes also did not contain an explanation for the delay. Because the EHR facilitates communication and continuity of care among healthcare professionals, inaccurate and late EHR documentation may have impacted the clinical team's ability to fully evaluate and plan the patient's immediate treatment and to monitor the patient's health care over time.[73]

[68] VHA Handbook 1907.1, *Health Information Management and Health Records*, March 19, 2015. The entry date of the EHR note identifies when the documentation actually occurred.

[69] VHA Handbook 1907.1.

[70] Facility policy.

[71] VHA Handbook 1907.1.

[72] Facility policy.

[73] VHA Handbook 1907.01; Facility policy.

Conclusion

The OIG identified issues relating to the supervision and care of the Program patient.

Supervision issues involved inconsistent Facility policy directions for patient check-ins, staff compliance with VHA and Facility policies/procedures regarding the management of patient check-ins and missing patients when they failed to check-in, and random screening for drugs and alcohol abuse. The Building 2 unit staff failed to consistently apply the Program workbook, the RRTP Manual, or the RRTP Handbook requirements for patient check-in. However, the OIG found that Facility policy directions for check-ins in the three policies were different. Different policies may result in inconsistent application and confusion for patients and staff.

On two occasions when the patient did not check-in as required, staff did not follow the Facility policy for missing patients even though the patient was considered to be at a higher risk of harm. The patient attended group meetings and participated in individual therapy two to three times per weekday, during which staff observed and documented the patient's demeanor. On four occasions, the staff described the patient as having a different demeanor: drowsy, tired, and/or withdrawn. Though staff recorded these changes, they did not perform additional testing for alcohol or other substances as required by VHA and Facility policy.

The OIG identified issues relating to the care of the Program patient. Specifically, the OIG found that the Program staff did not develop and implement a timely and comprehensive IDTP, provide services during the weekends, reassess the patient's restrictions, and submit timely and accurate documentation as required by VHA and Facility policies/procedures. OIG was unable to assess whether the impact of these failures directly affected the patient's outcome.

The OIG made five recommendations.

Recommendations 1–5

1. The Facility Director ensures that Facility managers coordinate and implement uniform Program policies and procedures relating to supervision of patients, and that Facility staff consistently follow those policies and procedures.

2. The Facility Director ensures that the Mental Health Treatment Coordinator and interdisciplinary team develop and document the interdisciplinary treatment plan, as required by Veterans Health Administration and Facility policy.

3. The Facility Director ensures that the Program offers patient treatment, daily, as required by Veterans Health Administration.

4. The Facility Director ensures that Program managers regularly evaluate restrictions to patient privileges and methods to reinstate restricted or lost patient privileges, as required by Veterans Health Administration.

5. The Facility Director ensures that staff document Program patient care in the electronic health record within Veterans Health Administration and Facility requirements and timeframes.

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: May 14, 2018

From: Director, VA Healthcare System (10N10)

Subj: Healthcare Inspection— Supervision and Care of a Residential Treatment Program Patient at a VISN 10 Medical Facility

To: Director, Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (VHA 10E1D MRS Action)

1. I have reviewed and concur with *the findings and recommendations in* the OIG report entitled, "Supervision and Care of a Residential Treatment Program Patient at a VISN 10 Medical Facility".

(Original signed by:)

Jane Johnson, VISN 10 Quality Management Officer

for

Robert McDivitt, FACHE

Appendix B: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: May 14, 2018

From: Director

Subj: Healthcare Inspection— Supervision and Care of a Residential Treatment Program Patient at a VISN 10 Medical Facility

To: Director, VA Healthcare System (10N10)

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled, “Supervision and Care of a Residential Treatment Program Patient at a VISN 10Medical Facility”.
2. Corrective action plans have been established, with some being already implemented, and target completion dates have been set.

(Original signed by:)

Facility Director

Comments to OIG's Report

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

Recommendation 1

The Facility Director ensures that Facility managers coordinate and implement uniform Program policies and procedures relating to supervision of patients, and that Facility staff consistently follow those policies and procedures.

Concur.

Target date for completion: July 30, 2018

Director Comments

A multidisciplinary workgroup was established to review all Program policies and procedures relating to supervision of patients. The workgroup is charged with ensuring uniformity with supervision requirements amongst program handbooks. Additionally, the workgroup will identify potential barriers to facility staff adherence to following policies and procedures. Results from the workgroup will be presented to the Executive Leadership Board.

Recommendation 2

The Facility Director ensures that the Mental Health Treatment Coordinator and interdisciplinary team develop and document the interdisciplinary treatment plan, as required by Veterans Health Administration and Facility policy.

Concur.

Target date for completion: June 30, 2018

Director Comments

Formal refresher training on development and documentation requirements for interdisciplinary treatment plans as required by local policy will be conducted by the Mental Health Treatment Plan Coordinator with interdisciplinary program managers and staff. The Quality Management department will conduct monthly random audits to ensure compliance with policy requirements. The treatment plan audit results trending below threshold will be presented to the Executive Leadership Board.

Recommendation 3

The Facility Director ensures that the Program offers patient treatment, daily, as required by Veterans Health Administration.

Concur.

Target date for completion: July 30, 2018

Director Comments

The Program offers daily patient treatment as required by Veterans Health Administration. Patients are given a program schedule each week, however, weekend participation is not mandatory. Clinicians are now required to incorporate and document individualized patient expectations of weekend treatment in the treatment planning process. Staff accountability with the new requirement will be monitored by interdisciplinary program managers.

Recommendation 4

The Facility Director ensures that program managers regularly evaluate restrictions to patient privileges and methods to reinstate restricted or lost patient privileges, as required by Veterans Health Administration.

Concur.

Target date for completion: June 30, 2018

Director Comments

There is a weekly interdisciplinary team meeting to discuss approval of patient passes. Documentation of the discussion is now required for all restrictions. Program staff meet with each patient whose pass is denied for review of the behavioral contract.

Recommendation 5

The Facility Director ensures that staff document Program patient care in the electronic health record within Veterans Health Administration and Facility requirements and timeframes.

Concur.

Target date for completion: August 30, 2018

Director Comments

The Quality Management department will conduct a ninety-day medical record review to assist program managers in identifying gaps with interdisciplinary staff documentation according to Veterans Health Administration and local timeframes. Results of the review will be reported to program managers and the Executive Leadership Board.

Staff Acknowledgments

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