



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Patient Overdose Death in a
Residential Rehabilitation
Treatment Program at a
Veterans Integrated Service
Network 1 Medical Facility



OIG MISSION

To serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs (VA) through independent audits, inspections, and investigations.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

**Report suspected wrongdoing in VA programs and operations
to the VA OIG Hotline:**

www.va.gov/oig/hotline

1-800-488-8244



Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review the circumstances surrounding a Residential Rehabilitation Treatment Program (Program) patient's death from heroin overdose at a Veterans Integrated Service Network (VISN) 1 medical facility (facility).¹

In 2015, a veteran, who was enrolled in the Program, was found dead in a facility public restroom by maintenance staff. An autopsy subsequently revealed the cause of death was acute heroin intoxication and the manner of death was accidental.

Two days later, the OIG received a request to investigate the circumstances surrounding the patient's death and review the patient's healthcare. In 2017, the OIG Office of Investigations completed a review, closed the criminal case, and referred the matter to the OIG Office of Healthcare Inspections for an evaluation of patient-care related issues. OIG staff reviewed the patient's electronic health record and requested that the facility evaluate the patient's care and respond to OIG queries. After reviewing facility responses, the OIG opened a healthcare inspection.

Background

The Program, located at the facility, was designed to help patients through the recovery process by arranging housing and VA medical care. Patients resided at the facility and as part of their treatment, attended an outpatient substance abuse day program (SADP) at an off-site VA facility. Patients returned to the facility in the evening where they participated in additional programming in a structured residential environment.

Patient Care Review

On the Friday prior to the overdose, the patient attended an appointment with an addiction therapist to enroll in Medication Assisted Therapy (MAT). In MAT, patients received medications, such as methadone, buprenorphine, and Suboxone®,² which assisted with reducing opioid withdrawal symptoms and cravings. The MAT enrollment process was not completed prior to the patient's death. On the Sunday and Monday prior to the overdose, the patient had urine drug tests ordered; but, was unable to produce urine for the testing. Per VHA policy at the

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., Section 7332, *Confidentiality of Certain Medical Records*, January 3, 2012.

² Suboxone® is a combination of two medications, buprenorphine and naloxone.

time,³ when a patient refused or claimed the inability to produce a urine sample for drug-testing, staff were required to review the appropriateness of residential care to determine whether the patient should continue in the program and, if so, under what conditions. For this patient, no documented action was taken.

On Monday morning, a registered nurse on the SADP staff documented that the patient appeared to be sweating, had tremors, and was less engaged in treatment. That afternoon, a Program psychologist met with the patient. The psychologist stated in an interview the patient “was doing really well in the program” and that there was not anything that stood out to indicate the patient was using drugs or suicidal.

The next day, the patient entered a single person public bathroom on the main floor of the facility, which could be locked from within. The patient was scheduled to attend classes in the morning. At 11:17 a.m., a nurse documented that the patient did not attend morning classes. Facility staff were unsuccessful in contacting the patient by phone. In mid-afternoon, a Program psychologist documented notification of Program staff, the facility Director, the Suicide Prevention Coordinator, and the VA Police that the patient had not returned to the Program unit.

Later that evening, the patient was discovered unresponsive in the bathroom by a maintenance staff member. A Code Blue was initiated; however, the Code Blue team was dispatched to the wrong area. They subsequently arrived at the correct location, assessed the patient, and determined that resuscitation was futile because the patient appeared to have been dead for several hours.

Program Processes and Cardiopulmonary Resuscitation Reviews

The OIG determined that Program protocols, processes, and policies were not in place for initiating MAT; for tracking patients’ SADP no-shows; and updating urine drug testing/test (UDT) procedures. OIG staff also found deficiencies in the Cardiopulmonary Resuscitation Committee’s review of code delays.

MAT Protocol Review

In 2015, the facility did not have a protocol for initiating MAT for Program patients. While there was a process for Program patients to obtain MAT, some MH staff were unable to articulate the pathway. Through interviews, OIG staff determined that the protocols for initiating MAT for Program patients were not well understood by Program and addiction therapy staff.

³ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December, 22, 2010. This handbook was scheduled for recertification December 31, 2015 and has not yet been recertified or replaced.

SADP No-Show Processes Review

The OIG found that at the time of the patient's death, there was no SADP or Program process in place to track patients who failed to show ("no-showed") for a scheduled individual therapy appointment or required group therapy at the SADP. As a result of this patient's death, staff at the SADP created a tracking spreadsheet to document that Program staff were notified when a patient did not attend a scheduled appointment. This tracking sheet helped to document improved communication between SADP and Program staff, but lacked some key information, such as the time entries were made and which Program staff should be notified.

UDT Procedures and Policy Review

The OIG found that in response to the OIG hotline referral, Program staff developed a policy regarding patients who refused to provide a urine sample. The policy outlined patient UDT requirements, staff UDT collection and results review process, and steps staff should take when patients fail to provide a urine sample. OIG staff reviewed 40 electronic health records of patients enrolled in the Program between June 7 and July 7, 2017 and determined that Program staff were following their revised policy regarding UDT.

Cardiopulmonary Resuscitation Code Delay Review

The OIG found that the Cardiopulmonary Resuscitation Committee had not reviewed the code delay surrounding the patient's death because cardiopulmonary resuscitation was not initiated due to medical futility. As a result of the OIG review, the Cardiopulmonary Resuscitation Committee revised its medical emergency policy, to ensure the review of all codes including those that were cancelled due to medical futility.

While the facility had process deficiencies, the OIG cannot determine how or to what extent the deficiencies contributed to, or had impact on, the patient's death.

The OIG made three recommendations related to MAT education for Program and addiction therapy staff, SADP no-show procedures or policies, and staff training on SADP no-show procedures.

Comments

The Veterans Integrated Service Network and Medical Facility Directors concurred with the recommendations and provided an acceptable action plan. (See Appendixes A and B, pages 16–19 for the Directors' comments.) The OIG will follow up on the planned actions until they are completed.



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

Contents

| | |
|---------------------------------------------------------------|----|
| Executive Summary | i |
| Abbreviations | v |
| Introduction..... | 1 |
| Purpose..... | 1 |
| Background..... | 1 |
| Scope and Methodology | 6 |
| Case Summary | 8 |
| Inspection Results | 11 |
| Issue 1: Program Processes..... | 11 |
| Issue 2: Review of the CPR Committee and Code Blue Delay..... | 13 |
| Conclusion | 14 |
| Recommendations 1–3..... | 15 |
| Appendix A: VISN Director Comments..... | 16 |
| Appendix B: Facility Director Comments | 17 |
| Staff Acknowledgments..... | 20 |
| Report Distribution | 21 |

Abbreviations

| | |
|------|----------------------------------------------|
| CBOC | community based outpatient clinics |
| EHR | electronic health record |
| FY | fiscal year |
| MAT | Medication Assisted Therapy |
| MH | Mental Health |
| OIG | Office of Inspector General |
| RRTP | Residential Rehabilitation Treatment Program |
| SADP | Substance Abuse Day Program |
| UDT | urine drug testing/test |
| VA | Department of Veterans Affairs |
| VHA | Veterans Health Administration |
| VISN | Veterans Integrated Service Network |



Introduction

Purpose

The VA Office of Inspector General (OIG) conducted a healthcare inspection to review the circumstances surrounding a Residential Rehabilitation Treatment Program (RRTP) patient's death from heroin overdose at a Veterans Integrated Service Network 1 medical facility (facility).⁴

Background

The facility's specialized RRTP (Program) helps patients through the recovery process by arranging housing and VA medical care. In 2015, patients in the Program resided at the facility. During the day, patients attended an off-site substance abuse day program (SADP). Evening programming was offered in a structured residential environment at the facility.

Veterans Health Administration Mental Health Services⁵

The Veterans Health Administration (VHA) offers Mental Health (MH) services that focus on recovery throughout the spectrum of MH care. These MH services include Outpatient MH, intensive outpatient day treatment programs, RRTPs, and inpatient care, including locked inpatient units for patients requiring a more structured environment. The guiding premise behind VHA MH is that veterans with mental disorders and serious mental illnesses "can be active participants in their treatment and can improve and recover; that is, gain or regain the capacity to live a meaningful, self-determined life, and thrive in their communities."

MH RRTPs⁶

A MH RRTP provides professional and peer support in a structured, therapeutic environment, 24 hours a day, seven days a week. RRTPs offer rehabilitative and clinical care and address a range of problems related to MH, medical, vocational, educational, and social issues.⁷ Depending on the residential rehabilitative care model, services may include: assessment, rehabilitation plan development, therapeutic group and individual counseling, case reviews, case management,

⁴ 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.

⁵ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December, 22, 2010. This handbook was scheduled for recertification December 31, 2015 and has not yet been recertified or replaced.

⁶ VHA Handbook 1162.02.

⁷ VHA Handbook 1162.02.

meals, and dietetics.⁸ Patients on medications are taught practices related to safe management of their medication regimens to achieve independent medication administration.⁹

Although inpatient care requires that a patient remain hospitalized until discharged, RRTP patients, who reside within a residential unit, can sign out on a pass or attend classes outside of the medical center grounds. RRTPs promote recovery, increased independence, and community reintegration within a less restrictive treatment setting.¹⁰ VHA requires RRTPs to emphasize rehabilitative approaches that promote patient education and the practice of self-care skills.¹¹

The Program

The Program was a specialized MH RRTP that provided patients with a stable, supervised recovery environment for treatment due to the complexity of their conditions.

The Program model was designed to provide a structured, supportive residential environment as part of the rehabilitative treatment 24 hours a day, seven days a week. Admission may be self-directed or result from a referral from other programs, both within and outside of VHA. Upon admission, patients

- Are prohibited from using or possessing alcohol and non-prescription drugs, and
- Must agree to alcohol and drug screenings on a regular, random, or as-clinically-indicated basis as specified in their treatment plans (required at least weekly).

Patients are advised that if they do not adhere to the structured and supportive monitoring regime, they may be discharged from the Program.¹² According to VHA Handbook 1162.02, if a patient is discharged from an RRTP, facility staff must make arrangements for continuing VA and non-VA services for the patient's medical, addictions, and other MH needs.

Opioid Medications

Opioids

Opioids are a class of drugs that include prescription pain relievers such as oxycodone, hydrocodone, morphine, codeine, and fentanyl, as well as the illicit drug heroin. In addition to relief of pain, opioids can produce feelings of extreme well being referred to as euphoria. Common side effects include drowsiness, constipation, nausea/vomiting, and dizziness. At high

⁸ VHA Handbook 1162.02.

⁹ VHA Handbook 1162.02.

¹⁰ VHA Handbook 1162.02.

¹¹ VHA Handbook 1162.02.

¹² VHA Handbook 1162.02.

doses, opioids can cause respiratory depression and other physiological actions that can lead to death. With prolonged use, physical and/or psychological dependence can occur.¹³

Opioid Use Disorder

Opioids are associated with serious adverse health effects. According to the Centers for Disease Control and Prevention, deaths by opioid overdose exceeded 42,000 in 2016, more than any other year on record.¹⁴ Opioid use disorder is a problematic pattern of opioid use that leads to clinically significant impairment or distress; its symptoms include

...a strong desire for opioids, inability to control or reduce use, continued use despite interference with major obligations or social functioning, use of larger amounts over time, development of tolerance, spending a great deal of time to obtain and use opioids, and withdrawal symptoms that occur after stopping or reducing use, such as negative mood, nausea or vomiting, muscle aches, diarrhea, fever, and insomnia.¹⁵

Opioid use disorder treatment programs provide Medication Assisted Therapy (MAT).¹⁶ Patients can receive prescriptions for medications, such as methadone, buprenorphine, and buprenorphine/naloxone (Suboxone®), which assist with reducing opioid withdrawal symptoms, cravings, and risk of overdose.

Suboxone®

The VA/DoD (Department of Defense) *Clinical Practice Guideline for Management of Substance Use Disorders (SUD)* recommends that pharmacotherapy, such as buprenorphine or Suboxone®, be offered to patients who meet the criteria for diagnosis of opioid use disorder.^{17,18}

¹³ National Institute on Drug Abuse, Prescription Drug Abuse, <http://www.drugabuse.gov/publications/research-reports/prescription-drugs/opioids/what-are-opioids>. (This website was accessed March 18, 2016.)

¹⁴ Centers for Disease Control and Prevention, *Opioid Overdose*, <https://www.cdc.gov/drugoverdose/index.html>. (This website was accessed February 6, 2018).

¹⁵ Substance Abuse and Mental Health Services Administration, Opioid Use Disorder, <https://www.samhsa.gov/disorders/substance-use>. (This website was accessed January 5, 2017.)

¹⁶ Medication Assisted Treatment is the use of medication, counseling, and behavioral therapies in combination to treat substance use disorders. <https://www.samhsa.gov/medication-assisted-treatment>. (This website was accessed December 16, 2016.)

¹⁷ The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) provides diagnostic criteria for opioid use disorder that includes cravings to use opioids and persistence in using opioids despite disruptions to functional activities and causing interpersonal problems. <https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-fact-sheets>. Updated Disorders: Substance-Related and Addictive Disorders. 2017 web site. (This website was accessed September 12, 2017.)

¹⁸ VA/DoD *Clinical Practice Guideline For Management of Substance Use Disorders (SUD)*, August 2009. Suboxone® is a controlled substance that is a Food and Drug Administration approved opioid medication for the treatment of patients with opioid use disorder.

Suboxone® is a controlled substance, and a Food and Drug Administration-approved medication for the treatment of patients with opioid use disorder. Suboxone® 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. Use of Suboxone® should be part of a complete treatment plan including medical management, counseling, and psychosocial support.¹⁹

The prescription of Suboxone® is more regulated than most other opioids prescribed. Physicians must meet qualifications for a waiver to prescribe Suboxone® before the U.S. Drug Enforcement Agency will assign a special identification number. The Substance Abuse and Mental Health Services Administration (SAMHSA)²⁰ reviews and approves waiver applications after verifying a physician's medical licensure, Drug Enforcement Administration registration to prescribe controlled substances, and completion of training in the administration of Suboxone®.²¹

Urine Drug Testing²²

Urine drug testing/tests (UDT) is an integral part of any substance abuse treatment program. 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 patient's self-reporting or urine toxicology results.

According to VHA policy, patients are prohibited from using or possessing alcohol and non-prescribed drugs while residing in an RRTP. Patients must agree to alcohol and drug screenings on a regular, random, or as-clinically-indicated basis as specified in their treatment plan. Failure to provide a urine sample may result in the patient's discharge from the Program.²³

Oversight of Facility Cardiopulmonary Resuscitation Events

VHA requires that each facility have an established Cardiopulmonary Resuscitation (CPR) Committee or equivalent.²⁴ The committee is responsible for reviewing each episode of care

¹⁹ *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, Department of Health and Human Services Publication No. (SMA) 04-3939, 2004.

²⁰ SAMHSA is a federal agency, and the mission is to reduce the impact of substance abuse and mental illness on America's communities. <http://www.samhsa.gov/about-us>. (This website was accessed May 2, 2016.)

²¹ SAMHSA - How to Qualify for a Physician Waiver. <http://www.samhsa.gov/medication-assisted-treatment/buprenorphine-waiver-management/qualify-for-physician-waiver>. (This website was accessed March 29, 2016.)

²² *VA/DoD Clinical Practice Guideline For Management of Substance Use Disorders (SUD)*, August 2009.

²³ Handbook 1162.02.

²⁴ VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008. This directive expired October 31, 2013 and has not yet been replaced or recertified.

where resuscitation was attempted and reviewing all resuscitation events to identify problems, analyze trends, and benchmark opportunities for process and outcome improvements. When problems are identified, the committee is charged with recommending specific actions and ensuring implementation of identified action plans.

Ongoing review and analysis of high-risk healthcare processes and the remediation of identified problems are essential underpinnings for ensuring patient safety and the provision of high-quality care. In addition, VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008, directs the facility director (or their designee) to review each CPR event for errors or deficiencies in technique or procedure.

Concerns

In 2015, the OIG received a request to investigate the circumstances surrounding the patient's death and review the patient's health care. In 2017, the OIG Office of Investigations completed a review, closed the criminal case, and referred the matter to the OIG Office of Healthcare Inspections for an evaluation of patient-care related issues. OIG staff reviewed the patient's electronic health record (EHR) and requested the facility evaluate the patient's care and respond to OIG queries. After reviewing facility responses, the OIG opened a healthcare inspection.

Scope and Methodology

The OIG initiated a healthcare inspection on July 3, 2017. OIG staff reviewed the care provided prior to the patient's death and conducted a site visit.

OIG staff interviewed VISN and facility leaders including the VISN and facility Directors, Associate Director, Chief of Staff, Associate Director of Patient Care, a program Director and staff, a Program patient, SADP staff, and other individuals knowledgeable about the care and events related to the patient who died.

In addition, OIG staff conducted interviews with facility MH staff; VA Police; and Quality Management, Risk Management, and Patient Safety staff. OIG inspectors observed SADP's staff processes when a Program patient no-showed for an appointment.

To assess Program UDT, MAT, and appointment no-show processes, OIG staff reviewed VHA directives and handbooks, system policies, and standard operating procedures (SOP) that were in place at the time of and after the patient's death from 2015 through November 2017. OIG staff also reviewed the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5),²⁵ CPR Committee minutes, the peer review of the patient's care, root cause analyses, and the administrative investigation concerning the patient's death. OIG staff reviewed UDT logbooks for the 40 Program patients who had UDT orders from July 7 through August 7, 2017.

OIG staff reviewed the Office of the Chief Medical Examiner reports including autopsy, toxicology, and medical examiner reports. In addition, OIG staff reviewed VHA and city police reports concerning the patient's death, and Veritas eDiscovery email files.²⁶ The OIG requested a timeline based on Closed Circuit Television tapes recorded the day of the patient's death; however, according to the facility Acting Chief of Police, the tapes and timeline were no longer available.²⁷

The OIG reviewed the facility's external notifications to the OIG, Federal Bureau of Investigation, the local Police Department, VISN 1, and Congressional leaders and their staff to report the patient's death. On the day following the patient's death, The Joint Commission contacted facility leadership about the sentinel event.

²⁵ Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM 5) Fact Sheets, American Psychiatric Association. <https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/dsm-5-fact-sheets>. Updated Disorders: Substance-Related and Addictive Disorders. 2017. (This website was accessed September 12, 2017).

²⁶ Veritas is a search tool used to analyze email and other large volume electronic files.

²⁷ The facility did not have a policy on how long these tapes were kept; according to the Acting Chief of Police, the tapes were recorded over as memory space was required, roughly every 16–30 days.

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.

Case Summary

The patient, who was less than 30 years old, had severe opioid use disorder, mood disorder, and post-traumatic stress disorder; and died of an accidental heroin overdose in a bathroom at the facility in 2015 while a patient in the Program. (See Figure 1 for a timeline of events.) The patient had multiple previous VA admissions related to substance abuse, including more than 10 prior admissions in 2015.

The patient was admitted to a VISN 1 medical facility (VISN facility 1) in 2015 (Day 1) for opioid detoxification. Approximately two weeks later, shortly before a planned discharge, the patient was found unconscious in the bathroom, transported to a non-VA hospital Emergency Department, and was diagnosed with polysubstance overdose with undetermined intent. The patient was transferred from the non-VA hospital to a second VISN 1 facility (VISN facility 2) later that day for further evaluation and management. During interviews with VISN facility 2 staff, the patient admitted to taking an excess of pills prescribed to treat MH conditions, but denied suicidal intent. The patient also denied opioid use; however, a urine toxicology screen was positive for opioids, and the patient had heroin in some belongings. The patient was evaluated by a provider in the psychiatry service who determined the patient met criteria for an involuntary hospitalization.²⁸ While hospitalized, the patient underwent opioid detoxification, and providers made psychiatric medication adjustments. The patient was deemed safe for discharge from the inpatient MH unit on Day 40.

After discharge from VISN facility 2, the patient was admitted to the facility's Program. Upon admission, the patient denied suicidal ideation and declined MAT for an opioid use disorder. A urine sample was submitted for toxicology screening and the patient underwent breathalyzer testing, both with negative results. On Day 41, the patient spoke with an addiction therapist and agreed to MAT with the medication Suboxone® and subsequently presented to the Substance Abuse Outpatient Clinic to apply for admission into the Opioid Treatment Program to obtain MAT. The patient spoke with an addiction therapist at the Substance Abuse Outpatient Clinic and expressed uncertainty about whether to proceed with Suboxone®. The addiction therapist documented a plan to follow-up with the patient in two days.

On Day 42, the day after agreeing to start MAT, the patient began attending substance abuse recovery groups at an off-site SADP. At one of the groups that focused on the prevention of overdose from opioids, the patient was described as an "active participant" in the group. The patient met with an addiction psychiatrist that day and again agreed to participate in MAT "to give myself a chance." The patient also submitted a urine sample for toxicology screening and underwent breathalyzer testing, both with negative results.

²⁸ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008 (amended November 16, 2015). Para 10.d. (1), (2), (3).

The patient spoke with an addiction therapist on Day 43 and confirmed an interest in participating in the daily Suboxone® treatment program. The addiction therapy note documented that the patient would be informed of the date and time of the medical evaluation that was required prior to starting therapy. No evidence of a scheduled appointment was found in the patient's EHR.

The patient met with a Program psychologist on Day 46. The psychologist documented that the patient did not produce a urine specimen as requested for toxicology screening on Day 45 because of an inability to urinate. The psychologist also noted that the patient had been observed by SADP staff earlier on Day 46 "to be sweating and less engaged in treatment programming." The patient denied drug use to the Program psychologist. The psychologist planned to obtain a urine sample for toxicology screening later that evening.²⁹ No evidence of urine toxicology results from Day 46 was found in the EHR. A primary care nurse documented that she saw the patient who appeared "drowsy and unwell" on Day 46. She also noted tremors and "slowed speech," which the patient attributed to the effects of prescription medication.

On Day 47, at approximately 7 a.m., the patient entered a single person public bathroom at the facility, which could be locked from within. The patient was scheduled to attend classes at the SADP in the morning. A little before noon, an SADP nurse documented that the patient did not attend morning classes that day. She alerted the Program psychologist by adding the psychologist as an additional signer to an EHR note. The psychologist signed the note, acknowledging receipt of the information in early afternoon. Almost an hour later, the psychologist documented that the veteran had no other scheduled appointments that day, and the telephone number listed in the EHR was no longer in service. In mid-afternoon, the psychologist documented notifying Program staff, the facility Director, the Suicide Prevention Coordinator, and the VA Police that the patient had not returned to the Program.

Later that evening, the patient was discovered by a member of the facility's maintenance staff in the bathroom, approximately 13 hours after first entering it. A Code Blue was initiated. The code team was initially sent to the wrong location, which resulted in an approximate 10-minute delay. Upon arrival to the bathroom and examining the patient, the code team determined that resuscitative efforts would be futile. The patient was pronounced dead. An autopsy revealed the patient's cause of death was acute heroin intoxication and the manner of death was accidental.

²⁹ The psychologist documented the findings from the Day 46 meeting on Day 47, after receiving notification that the patient did not attend scheduled SADP sessions.

Patient Overdose Death in the Residential Rehabilitation Treatment Program at a VISN 1 Medical Facility

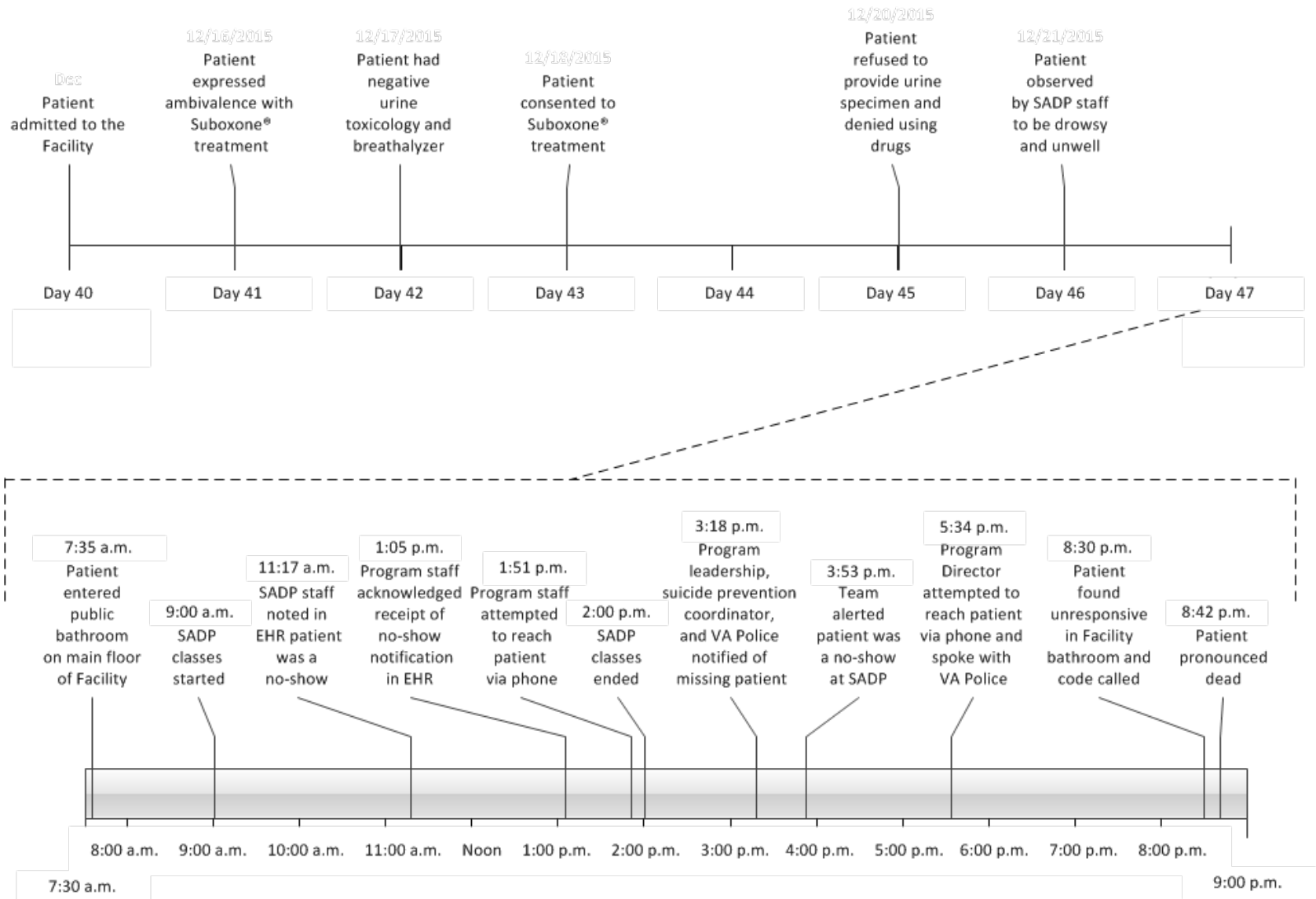


Figure 1. Timeline of Events Leading up to Death of the Patient

Source: VA OIG analysis of patient's EHR.

Inspection Results

Issue 1: Program Processes

The OIG determined that facility protocols were not in place for initiating MAT for Program patients or for tracking Program patients' no-shows to the SADP, and UDT policy was not followed.

Review of Delay in Initiating MAT Treatment with Suboxone®

The patient's MH treatment coordinator initiated a MAT referral the day following the patient's admission to the Program. The patient expressed ambivalence about starting medication for opioid use disorder at that time due to past experience with tapering off opioids. On Day 43 (4 days after admission to the program) the patient agreed to treatment with Suboxone®. However, OIG staff found no evidence in the EHR that the medication was initiated in the four-day period between the consent and the patient's death. Facility staff stated that patients need to have a medical evaluation prior to initiating medication treatment for opioid use disorder. In the administrative review of the patient's death, a reviewer noted that the medical evaluation was scheduled on the day of the patient's death; however, there was no EHR documentation of a scheduled appointment. According to facility staff, this may have occurred because the request came in before a weekend. The Director of Addiction Recovery Services stated that in 2015, facility staff were unable to start a patient on Suboxone® on weekends.

Staff also stated that there was no specific protocol to start patients on Suboxone® in 2015, and the process had evolved since this time secondary to a national push to more aggressively place patients with opioid use disorder on Suboxone® or buprenorphine. However, the facility does not have a policy or SOP for this process and five facility MH providers—including the patient's Program psychologist, the associate Chief of Psychiatry, Director of the MAT Program, and two addiction therapists—said they either did not know or could not articulate the process for a Program patient to obtain Suboxone® therapy. As of September 26, 2017, scheduled appointments to start Suboxone® were not available outside of usual business hours. OIG staff were informed that psychiatrists in the facility's Emergency Department were privileged to provide Suboxone® so that patients who desired to begin the medication more urgently could access it after hours. However, as of August 2017, just over one-half of Emergency Department physicians were privileged to initiate this type of treatment if clinically indicated. OIG staff were also informed by a psychiatrist that this pathway was not frequently utilized because of a preference to have a comprehensive detoxification plan prior to starting therapy.

Review of No-Show Communication

The patient was scheduled to attend SADP classes at 9:00 a.m. on the day of death. A little before noon, an SADP nurse documented in the EHR that the patient was a no-show for a

scheduled SADP appointment. Approximately two hours later, the Program psychologist documented receipt of the nurse's message. The delays in notification would likely not have changed the outcome for the patient; however, it contributed to the delay in initiating a search for the patient.

As a result of the patient's death, SADP staff developed a no-show tracking process and database. Notification to Program staff is captured in a spreadsheet when a patient is a no-show. According to the spreadsheet, there were two SADP no-shows during an eight-month period in 2017. The first no-show Program patient was at a medical appointment and failed to notify SADP staff. For the second patient, the OIG team observed SADP staff calling the Program and trying to locate a patient when he no-showed for his appointment. The patient was found with his Peer Support Specialist.

While the OIG noted improvements in communication between the SADP and Program staff, there was no formal SOP or policy regarding steps to contact the Program staff if one of their patients no-showed for day treatment. In addition, while SADP staff developed a spreadsheet to track no-show patients, this document lacked some important details. For example, the spreadsheet did not log the time entries were made or identify the responsible staff member who was contacted at the Program about the patient's no-show.

Review of UDT Procedures

In 2015, at the time of the patient's accidental heroin overdose, VHA policy stated that

patients admitted to rehabilitation treatment programs must agree to alcohol and drug screenings on a regular, random, or as-clinically-indicated basis as specified in their treatment plan...[r]esidents who do not adhere to this monitoring policy must have careful review of their appropriateness for residential care and may be subject to discharge from the residential program. If a resident [patient] is discharged, continuing VA and non-VA services for medical, addictions, and other MH needs must be arranged.³⁰

On Day 40, according to EHR documentation, Program staff failed to collect a urine specimen because the patient indicated an inability to urinate. The patient's psychologist stated that staff were aware that the patient failed to provide a urine sample and the test was re-ordered for Day 41. However, the OIG found no evidence in the EHR of a UDT result for Day 41. The Program psychologist was unaware of reasons why staff did not complete the UDT order.

Since the patient's death in 2015, facility leaders and Program staff made a number of changes to the UDT process. In 2016, they created a UDT SOP that outlines patient UDT requirements, staff UDT collection and results review process, and steps staff should take when patients fail to

³⁰ VHA Handbook 1162.02.

provide a urine sample. Specifically, the new SOP states that “should the veteran continue to not provide a urine sample, he/she will be restricted to the residence until the time that a sample can be provided or a clinical team member or Psychiatry Admitting Officer of the Day meets with the veteran regarding the refusal.” The SOP requires that staff document actions taken in the EHR. In addition, Program nursing staff review UDT orders daily to ensure completion. The nursing supervisor reviews all Program UDT results daily in a nursing huddle.³¹

Program staff track UDTs and breathalyzer tests using a logbook. OIG staff reviewed UDT logs for 40 patients who had a UDT entered in the logbook for an eight-month period of time. OIG staff confirmed that all UDTs listed in the log books were completed as ordered. For patients with positive results, OIG staff found EHR documentation that appropriate actions were taken. For example, Program staff discharged one patient who had come into the Program with a negative urine drug screen and while in the Program had a positive test for cannabis. In other instances, patients were counseled or re-tested.

Issue 2: Review of the CPR Committee and Code Blue Delay

The OIG found that the CPR Committee did not initially review documentation related to the 2015 Code Blue delay. The Code Team was paged for an unresponsive patient found in a bathroom. The Code Team was initially dispatched to the wrong location, which delayed arrival to the correct location. The VA Police report documented that this delay was a few minutes in length. The delay did not ultimately affect the outcome as the patient’s body showed signs of rigor mortis.³² Facility staff stated that the CPR Committee did not initially review this code because it was canceled due to medical futility. According to VHA Directive 2008-063, *Oversight and Monitoring of Cardio Pulmonary Resuscitative Events and Facility Cardio Pulmonary Resuscitation Committees*, October 17, 2008, facilities are only required to review events where resuscitation has been attempted. On August 9, 2017, the CPR Committee called a special meeting to review this code and made a recommendation to update the code policy to include review of codes where resuscitation was not attempted. The proposed revision was completed October 6, 2017.

³¹ A nursing huddle is a brief staff meeting that occurs at the beginning of a shift to discuss patient care.

³² Rigor mortis is a temporary rigidity of a person’s muscles that typically begins within two to six hours after death. Rigor Mortis and Other Postmortem Changes. *Macmillan Encyclopedia of Death and Dying*. <https://www.encyclopedia.com/social-sciences/encyclopedias-almanacs-transcripts-and-maps/rigor-mortis-and-other-postmortem-changes>. (This website was accessed March 12, 2018).

Conclusion

The OIG reviewed the care provided to a Program patient who died of a drug overdose and determined that Program protocols, processes, and policies were not in place for initiating MAT, for tracking patients' SADP no-shows, and updating UDT procedures. OIG staff also found deficiencies in the CPR Committee's review of code delays.

In 2015, the facility lacked a protocol for initiating MAT for Program patients. In 2017, the OIG determined that a process for Program patients to obtain MAT was in place but that some MH staff were unable to articulate the pathway. Through interviews, OIG staff determined that protocols for initiating MAT for Program patients were not well understood by staff.

At the time of the patient's death in 2015, there was no process in place to track patients who no-showed for required SADP therapy. As a result of the patient's SADP no-show and death, SADP staff created a tracking spreadsheet to document when a Program patient was a no-show. This tracking sheet helped document improved communication between SADP and the Program but lacked some key information, such as the time entries were made and which Program staff were notified.

The facility developed a UDT policy that included information on how to handle patients who refused to provide a urine sample. In reviewing the UDT log and EHRs of Program patients, the OIG found that the facility was following the policy regarding UDT for the reviewed period of time.

The OIG determined that the CPR Committee had not initially reviewed the code delay surrounding the death of the Program patient because CPR was not performed due to medical futility. Since the OIG inquiry, the CPR Committee revised the facility's medical emergency policy, to allow for the review of all codes, including those that were canceled due to medical futility.

While deficiencies were found with the policies, procedures, and processes listed above, the OIG could not determine how or to what extent the deficiencies contributed to, or had impact on, the Program patient's death. Since the patient's death, facility leaders have created an UDT SOP that outlined patient UDT requirements, staff UDT collection and results review process, and steps staff should take when patients fail to provide a urine sample. In addition, the CPR Committee has taken steps towards formalizing a change to expand its review of codes.

The OIG made three recommendations.

Recommendations 1–3

1. The VISN 1 Medical Facility Director ensures that staff receive education about the process for initiating Medication Assisted Therapy for patients enrolled in the Program.
2. The VISN 1 Medical Facility Director ensures that a standard operating procedure is issued to effectively track patients enrolled in the Program who fail to show for appointments at off-site substance abuse day programs.
3. The VISN 1 Medical Facility Director ensures that all appropriate staff receive training regarding the standard operating procedure for tracking patients enrolled in the Program who fail to show for appointments in at off-site substance abuse day programs.

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 13, 2018

From: Director, VA New England Healthcare System (10N1)

Subj: Healthcare Inspection—Patient Overdose Death in a Residential Rehabilitation Treatment Program at a VISN 1 Medical Facility

To: Director, Washington DC Office of Healthcare Inspections, (54DC)

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

1. I have reviewed and concur with the OIG findings and recommendations in the report entitled, *Patient Overdose Death in a Residential Rehabilitation Treatment Program at a VISN 1 Medical Facility*.
2. If you have any questions, please contact the Quality Management Officer for VISN 1 at (781) 687-4979.

(Original signed by:)

Barrett J. Franklin
Acting VISN 1 Network Director

Appendix B: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: April 12, 2018

From: Director, VISN 1 Medical Facility

Subj: Healthcare Inspection—Patient Overdose Death in a Residential Rehabilitation Treatment Program at a VISN 1 Medical Facility

To: Director, VA New England Healthcare System (10N1)

1. I have reviewed and concur with the OIG findings and recommendations in the report entitled, *Patient Overdose Death in a Residential Rehabilitation Treatment Program at a VISN 1 Medical Facility*.
2. Thank you for the opportunity to review and address the allegations and findings. We have provided an action plan to address the findings. If you have any questions concerning this matter, please contact the Chief of Staff.

(Original signed by:)

VISN 1 Medical Facility

Comments to OIG's Report

Recommendation 1

The VISN 1 Medical Facility Director ensures that staff receive education about the process for initiating Medication Assisted Therapy for patients enrolled in the Program.

Concur

Target date for completion: July 1, 2018

Director Comments

The VISN 1 Medical Facility Mental Health Service Line will ensure that staff will receive education about the process for patients to obtain Medication Assisted Therapy for Veterans with Opioid Use Disorder (OUD) admitted to the Program. Staff to be trained include all staff in the Program, staff in the substance abuse day program, and staff in Emergency Department. Initial training will be provided in-person and will be completed by May 1, 2018. A TMS training module will be developed and implemented for both new employees as well as for annual refresher training and will be completed by July 1, 2018. Target for compliance with training completion is 100% and will be monitored by the Mental Health Council.

Recommendation 2

The VISN 1 Medical Facility Director ensures that a standard operating procedure is issued to effectively track patients enrolled in the Program who fail to show for appointments at off-site substance abuse day programs.

Concur

Target date for completion: May 1, 2018

Director Comments

The VISN 1 Medical Facility Mental Health Service Line implemented a process in 2016 regarding no show procedures. The process has been formalized into a standard operating procedure and will be implemented with training as noted in recommendation 3. The Facility has been monitoring compliance since 2016 with the process for no-show noting an overall compliance of 100% with the process and will continue to evaluate compliance and report it through Patient Safety.

Recommendation 3

The VISN 1 Medical Facility Director ensures that all appropriate staff receive training regarding the standard operating procedure for tracking patients enrolled in the Program who fail to show for appointments at off-site substance abuse day programs.

Concur

Target date for completion: July 1, 2018

Director Comments

The VISN 1 Medical Facility Mental Health Service Line will ensure that all appropriate staff receive training about the standard operating procedure for no-show procedures for the Program patients in substance abuse day programs. Staff to be trained include all staff in the Program and staff in the substance abuse day programs. Initial training will be provided in-person and will be completed by May 1, 2018. A TMS training module will be developed and implemented for both new employees as well as for annual refresher training and will be completed by July 1, 2018. Target for compliance with training completion is 100% and will be monitored by the Mental Health Council.

Staff Acknowledgments

| | |
|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------|
| Contact | For more information about this report, please contact the OIG at (202) 461-4720. |
| Inspection Team | Laurie F. Thurber, MPP, Team Leader Donna Giroux, RN, BSN Robin Moyer, MD, MBA John Rumbaugh, MA, MBA Randall Snow, JD Andrew Waghorn, JD |
| Other Contributors | Robert Breunig, Special Agent Laura Dulcie, BSEE Kathy Gudgell, RN, JD Natalie Sadow, MBA |

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
VISN 1: Director, VA New England Healthcare System (10N1)
Connecticut: Director, VA Connecticut Healthcare System (689/00)
Maine: Director, VA Maine Healthcare System (402/00)
Massachusetts: Director, Edith Nourse Rogers Memorial Veterans Hospital (518/00)
Director, VA Boston Healthcare System (523/00),
Director, VA Central Western Massachusetts, Healthcare System (631/00)
New Hampshire: Director, Manchester VA Medical Center (608/00)
Rhode Island: Director, Providence VA Medical Center (650/00)
Vermont: Director, White River Junction VA Medical Center (405/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and
Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and
Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate:
Connecticut: Richard Blumenthal, Christopher Murphy
Maine: Susan Collins, Angus King
Massachusetts: Elizabeth Warren, Ed Markey
New Hampshire: Jeanne Shaheen, Maggie Hassan
Rhode Island: Jack Reed, Sheldon Whitehouse
Vermont: Bernie Sanders, Patrick Leahy
U.S. House of Representatives:
Connecticut: Joe Courtney, Elizabeth Esty, Rosa DeLauro, Jim Himes, John B. Larson,
Chris Murphy
Maine: Chellie M. Pingree, Bruce Poliquin
Massachusetts: Michael E. Capuano, Katherine Clark, Joe Kennedy III, Bill Keating,
Stephen F. Lynch, Jim McGovern, Richard E. Neal, Seth Moulton, Niki Tsongas
New Hampshire: Annie Kuster, Carol Shea-Porter
Rhode Island: David L. Cicilline, Jim Langevin
Vermont: Peter Welch

OIG reports are available at www.va.gov/oig