DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Inpatient Security, Safety, and Patient Care Concerns at the Chillicothe VA Medical Center

Ohio

HEALTHCARE INSPECTION | REPORT #17-04569-262 | SEPTEMBER 12, 2018

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in 2017 in response to requests from Senators Sherrod Brown and Jon Tester to review the care of a patient who fell to his death from a second-story window at the Chillicothe VA Medical Center (Facility), Ohio. The OIG reviewed the patient's electronic health record (EHR) and focused its inspection on two specific allegations:

- Adequate security and safety measures were not in place.
- The patient failed to receive the appropriate level of care at the Facility.

The OIG received an additional request from Senator Brown to determine whether the Facility provided grief counseling for family and staff.

The OIG substantiated that adequate security and safety measures were not in place for patients who might attempt to exit the Facility improperly. These deficiencies contributed to the patient's death.

Interviews with staff confirmed that external windows on the inpatient medicine unit were not secured shut or limited in width of opening as required by Veterans Health Administration (VHA) policy. Window security was not inspected during the Facility's annual workplace evaluation process. For this patient on special observation, an ability to lock the bathroom door was a safety issue that required staff intervention when the patient locked the door and climbed out the unsecured window.

For the patient's safety, he was "pink-slipped" (placed under temporary hospital detention for emergency treatment) to ensure he did not harm himself or others and did not leave the Facility against medical advice.

Also for safety purposes, the patient was placed on special observation. According to the Facility's special observation policy, a special observer (SO) "must remain at arm's length of the patient unless specifically directed otherwise…" The order entered into the EHR for this patient's special observation included the instructions "[s]taff at all times with this Veteran. Observation Level: eye sight." The SO was unable to keep the patient under visual observation for the few moments it took the patient to climb out the bathroom window after entering, closing, and locking the bathroom door. Although the SO attempted to rescue the patient by grabbing him, the patient slipped from the SO's grasp and fell to his death.

The OIG determined that staff did not adhere to the Facility's SO policy related to the content, frequency, and handoff documentation requirements. Facility leaders failed to monitor staff compliance with SO documentation requirements.

Staff training records indicated that numerous staff who worked on the unit did not complete the Prevention and Management of Disruptive Behavior training, the special observer competencies, and other required trainings. Facility leaders failed to ensure that staff were trained and competent, which likely contributed to staff being unaware of the SO guidelines and duties.

The OIG did not substantiate that the patient failed to receive an appropriate level of care at the Facility. The patient had both medical and mental health (MH) conditions. Due to his medical conditions, he could not be admitted to a locked mental health unit but was admitted to an open acute medical care unit with both medical and MH providers. He had orders for one-to-one observation for his safety.

The OIG determined that the Facility offered grief counseling to the patient's available family and staff. The Facility made repeated efforts to offer grief counseling services to the patient's designated next-of-kin. The Facility provided immediate crisis intervention and grief counseling for staff through the Employee Assistance Program.

The OIG found that the Facility's attempt to provide an institutional disclosure was inadequate. The patient's EHR does not contain documentation that the Facility disclosed all significant facts to a surviving family member, including evidence that the patient may not have committed suicide but accidentally fell to his death through an unsecured window. Additionally, the Facility did not attempt to locate the patient's adult child, who though estranged from the patient and not listed by the patient as his next-of-kin in the EHR, would have a superior claim to pursue legal action.

The OIG recommended that the Facility Director

1. Ensure that the windows of patient care areas remain secure in accordance with VHA Center for Engineering and Occupational Safety and Health guidelines,
2. Make certain that the Facility's policy for Special Observation is followed and monitored for compliance,
3. Verify that training and staff competencies are completed for Prevention and Management of Disruptive Behavior and Special Observation as required, and
4. Confer with the Office of Chief Counsel regarding the notification of the patient's death and discussion of institutional disclosure with the next-of-kin and take action as appropriate.

Comments

The Veterans Integrated Service Network and Facility Directors concurred with the recommendations and provided acceptable action plans. (See Appendixes A and B, pages 24–28 for the Directors' comments.) The OIG will follow up on the planned actions until they are completed.

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Contents

Abbreviations

AWE	Annual Workplace Evaluation
EAP	Employee Assistance Program
EHR	electronic health record
FY	fiscal year
LPN	licensed practical nurse
MH	mental health
MOD	Medical Officer of the Day
NA	nursing assistant
OIG	Office of Inspector General
PA	physician assistant
PMDB	Prevention and Management of Disruptive Behavior
RN	registered nurse
SO	special observer
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 in 2017 in response to requests from Senators Sherrod Brown and Jon Tester to review the care of a patient who fell to his death from a second-story window at the Chillicothe VA Medical Center (Facility), Ohio. The OIG specifically addressed allegations related to the Facility's security and safety measures and the patient's level of care. The OIG also reviewed an additional request from Senator Brown related to the provision of grief counseling for family and staff.

Background

The Facility, part of Veterans Integrated Service Network (VISN) 10, provides acute and chronic mental health (MH) services, primary and secondary medical services, extended care, and a wide range of nursing home care services. It also serves as a chronic MH referral center for other VA facilities in southern Ohio.

The Facility's ambulatory care setting includes several MH services and specialized women veterans clinics. Patients requiring tertiary medical services are referred to VA facilities in Cincinnati (105 miles) or Dayton (75 miles), Ohio. The Facility operates five community based outpatient clinics in Athens, Cambridge, Lancaster, Marietta, and Portsmouth, and one Outreach Clinic in Wilmington, Ohio. The Facility served over 22,000 patients in fiscal year 2017 and operates 295 beds, including 55 inpatient beds, 78 domiciliary beds, and 162 community living center beds. The Facility is affiliated with the Ohio University Heritage College of Osteopathic Medicine, A.T. Still University School of Osteopathic Medicine (Arizona), West Virginia School of Osteopathic Medicine, Kettering Health Network Grandview Medical Center (Dayton, Ohio), and The Ohio State University Colleges of Optometry and Dentistry for the purposes of education and training.

Security and Safety Measures

Physical Security

The Annual Workplace Evaluation (AWE) is an inspection required at each Veterans Health Administration (VHA) facility and is comprised of a safety and industrial hygiene evaluation. Qualified VISN occupational safety and health staff perform these inspections in collaboration with a team of facility representatives. The VHA Center for Engineering and Occupational Safety and Health provides an AWE process guide and program review checklists. When new environmental workplace concerns arise, these checklists are modified or expanded to include

special focus program areas. The items out of compliance during the AWE are remediated through an abatement plan approved by facility and VISN Directors.[1]

AWE criteria require that VHA facilities control window openings to prevent access to the outside of buildings.[2] Circular 10-84-17 was issued in 1984 when the Medical Inspector and Evaluation Office identified 58 incidents from January 1982 through July 1983 where patients jumped through healthcare facility windows or from roofs.[3]

In September 2015, VA National Center for Patient Safety published *Changes and Challenges in Architectural & Physical Plant Action Implementation by VHA Facilities from 2000–2015*, that identified architectural physical plant changes by facilities to prevent adverse events. In the acute care setting, one action taken to improve window security was to install two steel brackets per window to prevent the window from opening more than six inches.[4]

Special Observation[5]

Facility policy defines special observation as one staff to one patient observation and is the most protective and restrictive monitoring level for high-risk patients. A special observation order is written to prevent patients who are unable or unwilling to follow instruction from injuring themselves or others. The Facility policy requires uninterrupted observation and a special observer (SO) to be within arm's length of the patient 24 hours a day unless specifically directed otherwise. Outings off the unit for necessary health-related activities such as medical or legal issues require two staff to remain with the patient.

Facility policy requirements for special observation relevant to this report include

1. Registered nurse (RN) progress note completed at least every eight hours documenting
    - The level of observation,
    - Time patient was placed in observation,
    - Reason for observation,
    - Patient response to alternatives attempted, and

[1] VHA Directive 7701, Comprehensive Occupational Safety and Health Program, pg. 11, May 5, 2017.

[2] VA Circular 10-84-17, Control of Window Openings and Areas Unsafe for Patients in Health Care Facilities, February 3, 1984.

[3] VA Circular 10-84-17.

[4] VA National Center for Patient Safety, Changes and Challenges in Architectural & Physical Plant Action Implementation by VHA facilities from 2000-2015, pg. 7, September 2015.

[5] Chillicothe VA Medical Center Memorandum (MCM) 11-150, *Management of Special Observation (SO) Status*, January 15, 2016.

- Behavior and rationale for continuing observation.

2. SO staff member documenting the following every hour on the SO template in CPRS
   - Patient's orientation,
   - Activity,
   - Breathing,
   - Behaviors,
   - Location; and
   - Any medical equipment.
3. Observation Plan/Handoff Communication Form Documentation is
   - Completed upon initiation of special observation;
   - Reviewed, updated, and signed every shift by the RN and the SO; and
   - Reviewed with each handoff that occurs between patient care observers.

The patient on special observation must not be unattended for any reason. The SO should be assigned a computer on wheels for documentation purposes while staying with the patient.

Emergency Hospitalization for Involuntary Psychiatric Hold

Any licensed physician in Ohio may involuntarily detain a patient in a hospital for up to 72 hours (excluding weekends and holidays) without court approval and provide emergency psychiatric treatment.[6] This is commonly referred to as an involuntary psychiatric hold, or "pink slip," which must be approved by the chief clinical officer of the hospital or his designee.[7] The Facility did not have a policy that designated or defined the role of the chief clinical officer or designee.

To support the decision to enter an order for an involuntary psychiatric hold, the physician must reasonably believe the patient is "a mentally ill person subject to court order."[8] Mental illness is defined as "a substantial disorder of thought, mood, perception, orientation, or memory that grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary

[6] Ohio Revised Code, Section 5122.10.

[7] Ohio Revised Code, Section 5122.10; Chillicothe Policy Memorandum 122-01, *Involuntary Hospitalization*, November 21, 2016.

[8] Ohio Revised Code, Section 5122.10.

demands of life."[9] A mentally ill person is subject to court-ordered psychiatric treatment if he/she

> (1) represents a substantial risk of physical harm to self as manifested by recent threats of, or attempts at, suicide or serious self-inflicted bodily harm;
>
> (2) represents a substantial risk of physical harm to others as manifested by recent homicidal or violent behavior;
>
> (3) represents an immediate risk of serious physical impairment or injury to self because mental illness renders the person unable to provide for basic physical needs and appropriate provision for those needs cannot be made immediately available in the community; or
>
> (4) is in need of treatment for the mental illness as manifested by behavior that creates a grave and imminent risk to the person's substantial rights, or the substantial rights of others.[10]

To hold a patient beyond the 72-hour period, the chief clinical officer of the hospital must obtain the patient's consent for a voluntary admission, or file an affidavit requesting the probate court to order inpatient psychiatric treatment.[11]

Training

Prevention and Management of Disruptive Behavior

An interdisciplinary team conducts a Workplace Behavioral Risk Assessment each year and determines workplace risk level based upon the number of disruptive behavioral incidents that occurred in that workplace in the previous year. A disruptive behavior is defined as intimidating, threatening, or dangerous behavior that could jeopardize the health or safety of patients, employees, or individuals at the facility. Prevention and Management of Disruptive Behavior (PMDB) initial training must be completed by all employees within 90 days of hire to include all requirements based on the workplace location.

Level I PMDB training is required for all staff; level II training is required for staff who are assigned to low, moderate, and high-risk work areas; level III is required for those staff assigned

[9] Ohio Revised Code, Section 5122.01.
[10] Ohio Revised Code, Section 5122.01(B).
[11] Ohio Revised Code, Section 5122.10.

to moderate and high-risk work areas; and level IV is required for all staff assigned to high-risk work areas.[12]

The Facility inpatient medicine unit is designated as a moderate-risk workplace.[13] Staff who interact with patients on the inpatient medicine unit are required to complete PMDB training for a moderate risk workplace that consists of levels I–III within 90 days of being assigned to the unit and biennial skills assessment with retraining if skills assessment is not passed for levels II and III.

Competency Evaluations

Facility policy requires the service chief/care line manager to implement and maintain ongoing competency evaluation for each employee to include specific items:

- Ensure competencies are position specific to each employee.
- Identify and assess required competencies.
- Complete competency assessment documents.
- Maintain appropriate level of confidentiality with respect to competency assessment plans.[14]

At a minimum, each supervisor processes an annual assessment for qualifying employees who have had no changes to their position during the appraisal year. For new employees, employees occupying a new position within the service/care line, or employees who are new to the service/care line, the assessment includes orientation to the new job/procedure, an initial assessment, a 90-day assessment, a six-month assessment, and an annual assessment.

Special Observer Training

Facility staff are required to complete the necessary training and demonstrated competency before being assigned the duties of a special observer (SO).[15] This is comprised of two documents: the Sitter Guidelines/Expectations checklist and a Veteran Companion Performance Competency Assessment, both of which should be completed within 90 days followed by a six-month and end of year re-assessment.

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[12] VHA Directive 2010-026, Sexual Assaults and Other Defined Public Safety Incidents in VHA Facilities, 2012; Deputy Under Secretary for Health for Operations and Management Memorandum, Meeting New Mandatory Safety Training Requirements using Veterans Health Administration's Prevention and Management of Disruptive (PMDB) Curriculum, November 7, 2013.

[13] Chillicothe VA Workplace Behavioral Risk Assessment, December 14, 2016.

[14] Chillicothe Policy Memorandum 05-13, *Competency Assessment*, November 18, 2015.

[15] Chillicothe Policy Memorandum 11-50.

Grief Counseling

Family

Grief counseling is provided to the next-of-kin of patients who die at the Facility. Facility leaders reported that although the Bereavement Program policy refers specifically to the end-of-life care needs of Community Living Center patients, bereavement services are provided to families of patients who die on the medicine unit.[16] The OIG did not find additional VA or Facility guidance related to the provision of bereavement or grief counseling following a patient's death while in VA care.

The Facility policy requires post-death bereavement follow-up services within a week, to include mailed correspondence of a sympathy card and bereavement literature followed by a phone call within two weeks of the patient's death. Follow-up support for the surviving next-of-kin continues and is documented in the EHR for 13 months unless he/she requests that services cease.[17]

Staff

The Office of Personnel Management provides guidance on federal agency administration of Employee Assistance Programs (EAPs), which are voluntary, work-based programs that provide cost-free, confidential, short-term counseling services to employees who have personal and/or work-related problems that may affect aspects of their employment.[18, 19] An EAP is an important resource in responding to the counseling needs of employees affected by a critical incident,[20] such as workplace assaults and unnatural deaths.[21]

[16] Chillicothe Medical Center Memorandum, 122-08, *Bereavement Program*, March 4, 2015.

[17] Chillicothe Medical Center Memorandum 122-08.

[18] United States Code (2011), Title 5, Chapter 79 §7901, Health Service Programs, enables all government agencies under the Executive Branch except the Armed Forces to establish an Employee Assistance Program (EAP). Public Law 79-658 authorized the expansion of EAP services to provide brief assistance with personal problems that may affect their work.

[19] OPM Guidelines, *Federal Employee Assistance Programs*, September 2008.

[20] OPM Guidelines, Federal Employee Assistance Programs.

[21] OPM Guidelines, Federal Employee Assistance Programs.

Institutional Disclosure

An institutional disclosure is a formal process by which facility leaders[22] and clinicians inform a patient or his/her personal representative[23] that an adverse event occurred during the patient's care that resulted in, or is reasonably expected to result in, serious injury[24] or death. Facility leaders must initiate an institutional disclosure whether or not the adverse event resulted from a facility or medical error.[25] Ideally, an institutional disclosure should be completed within 72 hours of the adverse event, but disclosure may be delayed where necessary to gain all relevant facts, pending completion of an investigation into the incident.[26] Institutional disclosures should be face-to-face[27] meetings between facility leadership and the patient or the personal representative. All institutional disclosures must include

- A "forthright and empathetic discussion of clinically-significant facts," and[28]
- Information about how to file claims for compensation under 38 U.S.C., Section 1151 (disability compensation for disease or injury sustained by veterans as a result of VA medical treatment) and the *Federal Tort Claims Act* (FTCA).[29]

Facility leaders or the risk manager must engage in ongoing communications with the patient or the personal representative to keep them apprised of all pertinent information that emerges from investigation of facts related to the adverse event.[30] The institutional disclosure must be

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[22] VHA Handbook 1004.08, *Disclosure of Adverse Events to Patients*, October 2, 2012 (corrected October 12, 2012). Sections 2, 8. This Handbook was due for recertification on or before the last working date of October 2017 and has not been updated; see also Section 8 b, c. Facility leaders include the Medical Center Director, the Chief of Staff, the Associate Director for Patient Care Services (Nurse Executive), and others as appropriate. At the discretion of the facility, the Risk Manager, the Patient Safety Manager, treating healthcare providers, and/or a mental health professional may attend the disclosure meeting.

[23] VHA Directive 1605.01, *Privacy and Release of Information,* August 31, 2016. Section 5b (1)-(4). A personal representative is a person who is recognized under federal, state, or local law as possessing authority to exercise the rights, or otherwise act on behalf, of a living person (i.e. person holding a power of attorney, legal guardian, or conservator), or on behalf of a decedent's estate (i.e. executor or next-of-kin). When there is more than one surviving next-of-kin, the personal representative will be determined based on the following hierarchy: spouse, adult child, parent, adult sibling, grandparent, adult grandchild, or close friend.

[24] VHA Handbook 1004.08, Section 8 a. Serious injury includes significant or permanent disability, or injury that leads to prolonged hospitalization, requires life-sustaining intervention, and/or intervention to prevent impairment or damage, such as "sentinel events" as defined by The Joint Commission.

[25] VHA Handbook 1004.08, Section 8 a.

[26] VHA Handbook 1004.08, Sections 8 a (2).

[27] VHA Handbook 1004.08, Section 8 d. If not conducted in person, a note must be entered into the patient's electronic health record explaining why a face-to-face disclosure was not practical.

[28] VHA Handbook 1004.08, Section 3 d.

[29] VHA Handbook 1004.08, Section 8 g, 6, October 2, 2012.

[30] VHA Handbook 1004.08, Section 8 k, October 2, 2012.

documented in the patient's EHR using the "Institutional Disclosure of Adverse Event" note template and all subsequent correspondence with the patient or the personal representative must be documented in addendum notes in the patient's EHR.[31]

Allegations

In response to congressional inquiries from Senators Sherrod Brown and Jon Tester, the OIG conducted a healthcare inspection to review the care of a patient who fell to his death from a second-story window at the Facility. The OIG reviewed the patient's EHR and focused its inspection on two specific allegations:

- Adequate security and safety measures were not in place.
- The patient failed to receive the appropriate level of care at the Facility.

Per an additional request from Senator Brown, the OIG also evaluated whether the Facility provided grief counseling for family and staff.

Scope and Methodology

The OIG initiated its inspection on August 22, 2017, and conducted a site visit of the medicine unit at the Facility on September 5–7, 2017. The inspection covered the care of a single patient focusing on the most recent admission in 2017. The OIG team reviewed relevant VA/VHA and Facility policies and procedures, incident reports, root cause analyses, staffing assignment sheets, staff training and competency records, and documentation of grief counseling to the family and staff; the AWE; the Workplace Behavioral Risk Assessment; the patient's EHR; and special observation documentation. The OIG team made rounds of the medicine unit, with direct observation of the patient's assigned room and bathroom.

The OIG team interviewed multiple staff members: a nurse manager, a nurse supervisor, inpatient medical physicians, psychiatrists, a physician assistant (PA), RNs, licensed practical nurses (LPNs), a nursing assistant (NA), SOs, and a suicide prevention coordinator.

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 substantiates an allegation when the available evidence indicates that the alleged event or action more likely than not took place. The OIG does not substantiate an allegation when the available evidence indicates that the alleged event or action more likely than not did not take

[31] VHA Handbook 1004.08, Sections 8 j.

place. The OIG is unable to substantiate or not substantiate an allegation when the available evidence is insufficient to determine whether or not an alleged event or action took place.

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.

Patient Case Summary

Prior Evaluations at the Facility

The patient, who had more than 20 hospitalizations at the Facility between 2001 through 2013, was 60ish. Most of the hospitalizations were for treatment of specific medical problems and behavioral health disorders.

In 2012, the patient requested admission to the Facility. He verbalized suicidal and homicidal ideation. He was involuntarily admitted to the psychiatry unit for care, and, at that time, the medical provider documented in the EHR that he had no reported history of suicide attempts. Three days later, the patient signed out of the Facility against medical advice. He was deemed stable for discharge, having denied any further suicidal or homicidal ideation.

The patient presented to the Facility urgent care center in 2013 after voicing intent to harm himself. A psychiatrist and medical physician treated the patient. The patient was discharged from the Facility two days later. The reason for the hospitalization was listed as suicidality.

From 2014 until summer 2017, the patient received most of his psychiatric care from the same psychiatrist and was treated for his behavioral health disorders with various medications. The treating psychiatrist documented no suicidal or homicidal ideations.

In mid-2014, the psychiatrist noted that the patient had been taking an anti-anxiety medication since 1998 and initiated a tapering regimen. By early 2016, the patient's anti-anxiety medication had been stopped. The psychiatrist changed medications twice in 2016 and ordered a third one in mid-2017.

Episode of Care Under Review

The patient was admitted to a non-VA hospital in 2017 (Day 1) for treatment of a certain medical condition and transferred to the Facility on Day 4.

The admitting Facility physician noted a low platelet count[32] and an elevated blood pressure along with other symptoms that could have been related to the patient's primary medical condition that had triggered the 2017 hospitalization. The physician also noted that while the patient was alert and oriented to time and space, he seemed to confabulate.[33] The physician conducted a Delirium Risk Evaluation and determined the patient to be at low risk for delirium.

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[32] Platelets are cells found in the blood. Platelets play an important role in helping blood to clot. Generally, lower numbers of platelets mean that the blood will clot less quickly, possibly leading to a propensity to bleed. In this patient's case, the reason for the patient's low platelet count was unclear.

[33] Confabulation is the fabrication of events that may be used to fill in gaps in memory. https://www.merriam-webster.com/dictionary/triage. (The website was accessed on September 6, 2018.)

The patient was admitted to the general medicine service on a medical unit for further evaluation with a consult for psychiatric services.

A psychiatry PA evaluated the patient shortly after admission. The patient stated he did not have hallucinations at that time but had both visual and auditory hallucinations prior to admission to the non-VA facility. The patient denied suicidal or homicidal thoughts. After consultation with a psychiatrist, the psychiatry PA ordered two medications to treat the patient's primary medical condition. The psychiatry PA ordered the patient be placed on special observation status to be within eye sight at all times "…for his own safety." Special observation was initiated within approximately 30 minutes.

About six hours after admission (around midnight), the SO assigned to observe the patient entered a note stating that the patient was talking a lot and pacing around the room. The patient stated, "I can't jump out of the window without a parachute." The patient's SO documented that the patient was getting agitated because he wanted to go smoke a cigarette but was told he was not allowed to go out at night to smoke. The SO entered into the EHR record that the patient was awake, restless, and conversational. About an hour later, the same SO entered a note in the EHR that stated the "Patient attempted to open the bathroom window. I believe patient is trying to find a way to smoke a cigarette since… was told that he cannot be taken outside. Patient is still very restless and pacing the room."

On Day 5, in the early morning, the SO note stated that the patient was upset over the special observation status. According to the note, the patient had "…been coming here for years and never had something like this…" A nursing note later that morning stated that the patient thought he was being punished by being placed under the special observation status. That same note documented that the patient denied thoughts of self-harm. About two hours later, the same RN, in a special observation note, stated that the patient met criteria for discontinuation of special observation status. However, the patient was continued under special observation status.

The patient's medical physician evaluated the patient around noon that day and noted that the patient's ammonia level was elevated.[34] The physician documented that the patient was alert and oriented, but still engaging in distracting conversation. The physician recommended medication to treat the high ammonia level and continuation of other medications. The patient's psychiatry PA evaluated the patient in the early afternoon and documented that the patient denied suicidal or homicidal ideation. The patient reiterated his desire to be taken off special observation status. The psychiatry PA consulted with the patient's medical physician and recommended continuing the special observation status.

[34] Elevated ammonia levels in the blood can interfere with brain function and result in a change of behavior or alertness (encephalopathy).

On Day 6, the patient endorsed some MH symptoms but denied psychosis or suicidal/homicidal ideation[35] to the psychiatry PA. The psychiatry PA administered a cognitive assessment test and determined the patient had cognitive impairment. The patient expressed frustration to the psychiatry PA about being maintained on special observation status. The psychiatry PA made no changes in the treatment plan. The patient's medical physician saw the patient and determined that the patient was more coherent, acknowledged the results of the cognitive assessment test, and agreed that special observation was still in order. The medical physician observed that the ammonia was "…improved but not normal." The patient wanted to go outside and smoke; the medical physician determined this may not be safe for the patient to do alone.

On Day 7, the patient's blood pressure was elevated; the patient became increasingly agitated and insisted on leaving the Facility. The medical physician ordered medication for the patient's blood pressure and instituted a 72-hour involuntary psychiatric hold (pink-slip). A psychiatric resident physician (resident) saw the patient for the first time during this admission on this day. An attending psychiatrist (psychiatrist) supervised the resident. The resident documented that the patient had reported diffuse pains and endorsed MH symptoms, but denied suicidal or homicidal intention.

The resident thought that the patient may have been having other MH symptoms and made some medication changes. The special observation status was continued.

On Day 8, the patient reported around noon to the resident that his mood was good and his sleep was great. He wanted to go outside. The patient reported no suicidal or homicidal ideation. The resident documented that the patient's thought process was coherent and goal-directed, but his judgement and insight were questionable. Medications were continued. The psychiatrist was in agreement with the resident's assessment and treatment plan.

Also on Day 8, an RN evaluated the patient for a Mental Health Residential Rehabilitation Treatment Program.[36] The RN denied the patient admission to the program on the basis that he was not psychiatrically stable, remained under special observation status, and would have difficulty participating meaningfully in groups. The RN recommended that outpatient individual sessions be considered.

On the evening of Day 8, an SO accompanied the patient off the unit to smoke outside of the building. The SO documented that the patient ran through the building with a "… lit cig…" [sic] and wanted to go home. The SO summoned a nurse and the police to help get the patient back to

[35] Psychosis is a condition of the mind characterized by a loss of contact with reality. Patients with symptoms of psychosis can be at increased risk for harming themselves or others and can be unable to meet their basic needs. Patients who have psychosis can exhibit many symptoms such as delusions, hallucinations, agitation, aggression, and disorganized thoughts. There are many causes of psychosis.

[36] This program is designed to provide residential rehabilitation and treatment services that address medical conditions, mental illness, and psychosocial deficits.

his room. The SO noted that the patient was "…still very upset." An RN and NA documented similar descriptions of the events. The RN documented that the patient kept saying "I don't know what is happening and why can't I go home. I have a home." The RN notified the physician and administered medication as ordered. The SO continued to be assigned throughout the evening; around midnight the patient was noted to say, "I only took 7 steps when I was outside, I was looking for a second cigarette."

After midnight, early on Day 9, the SO noted in the EHR that the patient said that everything the day prior was his fault. The patient kept saying "this is going to be the death of me…if I be good can I go back to my room." The SO documented explaining to the patient that he was in his room; however, the patient did not believe he was in his room.

A few hours later, the SO documented that the patient was oriented to person, but not to place, time, or date; he was awake, restless, and pacing in his room. A nursing note initiated soon thereafter stated "writer heard staff member screaming 'hey, we need help in here.'" The RN went to the patient's room and encountered two staff members who reported that the patient had "jumped out the window." The RN looked through the open window in the patient's bathroom and saw the patient lying on the ground. The nurse called the VA fire department and the nursing supervisor and went outside to provide assistance. The Medical Officer of the Day (MOD)[37] went with the nursing supervisor and found the patient on the ground. A nurse was with the patient and the MOD observed a large amount of blood on the ground in the area of the patient's right ear. Cardiopulmonary resuscitation was initiated by a nurse and stopped by the physician for reasons of futility. The patient was pronounced dead.

The physician who wrote the patient's discharge summary had one documented encounter with the patient, on the fourth day after admission. On the day of the patient's death, this physician contacted a member of the patient's family to give notification of "…the unexpected Death by Suicide…jumped out of the window & who was pronounced dead…by Medical Doctor On Call." The summary of the patient's admission, completed on the day that the patient died, listed the principal discharge diagnoses: "Suicide in the Hospital...Mental health Issues/Severe Behavior issues on SO status since admission and Pink Slipped… HTN [hypertension]." In the body of the summary report, the physician documented "Pt [patient] jumped out of the window & pronounced dead by MOD on call…"

The day after the patient expired, the Risk Manager, a suicide prevention coordinator, and the Chief of Ambulatory Care & Processing documented that they called a family member of the patient to initiate a formal institutional disclosure. The Risk Manager provided an overview of the process and offered the family member the opportunity to meet with a team to discuss the

[37] The Medical Officer of the Day is the designated physician or other practitioner who is physically present in an inpatient facility during periods when the regular medical staff is not on duty.

events surrounding the patient's death. The family member declined a formal disclosure at that time but "reserved the right to call back and schedule a meeting in the future." The group provided the family member the Risk Manager's phone number. The staff offered their condolences and furnished information regarding available bereavement support, administrative tort claims, and the veteran's burial benefits.

A suicide prevention coordinator completed a suicide behavior report two days after the patient died. The suicide behavior report documented that the patient's stated level of intent for suicide was high, the staff assessment of the level of intent of this event was high, and the staff assessment of the level of lethality of this event was high. The patient's pain score before the event was zero. The report further states that the "…veteran climbed out his room window and fell to his death" and that "…the veteran was being observed 1 to 1 due to being acutely psychotic."

Inspection Results

Issue 1: Security and Safety Measures

The OIG substantiated that adequate security and safety measures were not in place for patients on the medical floor who might try to exit the Facility improperly.

Physical Security

The OIG confirmed through interviews that the windows on the inpatient medical unit were not secured or limited in width of opening at the time of the incident as required by VHA and were not inspected through the AWE process. Staff further reported that the windows had been replaced in 2012 and that the windows were not secured prior to being replaced. A similar incident had occurred previously when a patient attempted suicide by trying to jump out of a bathroom window that opened fully. Staff members prevented him from going out of the window. However, no actions were taken to secure the windows.

The Facility 2017 AWE team did not identify the unsecured windows as being out of compliance with VHA requirements even though a window security requirement was part of the AWE evaluation tool. A Facility leader stated that the windows had been replaced and was unsure why locks had not been installed and denied that window security had been brought to the leader's attention.

The OIG team's EHR review indicated that the patient attempted to open the bathroom window trying to find a way to smoke as he was not allowed to be taken outside to smoke. At that time, the patient was in possession of cigarettes and a lighter even though Facility policy required that patients placed on special observation status be searched for items that can cause harm to self or others and all potentially dangerous objects removed from his access.[38] The absence of window security created an environment of severe danger for patients who were disoriented or suicidal and for staff assigned to protect these patients from harm.

As a result of this patient's death, Facility leaders implemented the following actions on the inpatient medicine unit to improve patient and staff safety: windows were locked, locks were removed from bathroom doors, and patients were no longer allowed to keep cigarettes and lighters.

[38] MCM 11-150.

Special Observation

According to the Facility's special observation policy, an SO "must remain at arm's length of the patient, unless specifically directed otherwise…"[39] The order entered into the EHR for this patient's special observation included the instructions "[s]taff at all times with this Veteran. Observation Level: eye sight." During interviews, some staff communicated that past practice was to permit patients on special observation with the order "within eye sight" to close the bathroom door when showering or using the bathroom for privacy. In response to this patient's death, Facility leaders changed the special observation order to default to "within arm's reach" and began monitoring SOs to ensure they were following the policy.

RN and SO EHR documentation did not meet the content and frequency requirements detailed in the Facility policy. The RN special observation template notes were missing required fields of information and some were not documented at least every eight hours as required. Five of 17 possible RN special observation progress notes were missing. Thirty-two (30 percent) of the 105 SO template notes were not completed hourly as required. Facility leaders failed to monitor staff compliance with the Facility's policy concerning special observation documentation and could not provide documentation of proper communication between staff when staff members changed.

In response to this patient's death, Facility leaders instructed Facility Nursing Officers of the Day to speak with patients on special observation and to get to know them. The Nursing Officers were to observe SO staff sitting with special observation patients to ensure staff were following policy, and if not, provide just-in-time training and inform the nurse manager of failures to follow the policy. An audit of the SO notes of patients on special observation was implemented to ensure staff were following orders.

Facility policy requires that the special observation "1:1 Observation Plan/Handoff Communication" form be completed at the initiation of special observation, updated and signed every shift by the RN and SO, reviewed each time a handoff occurs and maintained as part of the permanent EHR.[40] The OIG asked Facility leaders to provide the inspectors with the handoff forms from the patient at issue and they were unable to produce the forms.

Facility leaders failed to educate staff on the requirement to use the handoff form and failed to establish a process to monitor compliance. Without proper training and monitoring, SOs would be unaware of how to fulfill safety requirements that had been implemented to avert potential harm.

[39] MCM 11-150.
[40] MCM 11-150.

Emergency Hospitalization (Involuntary Psychiatric Hold)

The OIG found the patient's behavior warranted involuntary detainment for psychiatric treatment on Day 7 when the patient wanted to go home and frequently asked to leave. The patient had been admitted three days earlier for medical and MH conditions and exhibited some related signs and symptoms. An order was entered to place the patient on special observation "for his own safety." The patient refused to take blood pressure medication, claiming it caused hallucinations and was toxic, which required treatment with several additional medications throughout the hospital stay to manage unstable blood pressures. Two days earlier, he had attempted to open the bathroom window, requiring redirection. The patient believed his doctor was not a physician but a veteran he knew from a previous inpatient rehabilitation program admission. He became increasingly agitated to the point that treating providers believed it was necessary to administer medications to control disruptive behavior. The physician who signed the pink slip indicated that the patient's "speech was illogical." All of these factors supported the physician's assessment that the patient was "not deemed stable to leave the facility" due to being a danger to one's self and others.

The physician indicated that an involuntary psychiatric hold was required because the patient "would benefit from treatment in a hospital… and [was] in need of such treatment as manifested by evidence of behavior that [created] a grave and imminent risk to substantial rights of others or himself." Under the circumstances, temporary detention in a hospital to treat this patient who exhibited mentally unstable and disruptive behavior that placed him at imminent risk for self-harm, and who was not making good treatment decisions, was a reasonable treatment plan.

The patient became increasingly agitated over the next 40 hours. According to multiple reports by SOs, the patient simply wanted to go home and felt he was being punished for a previous attempt to leave the Facility when he was outside smoking a cigarette.

Training

Training records provided by the Facility indicated that numerous staff who worked on the inpatient medicine unit had not met the required PMDB training requirements. None of the 38 staff performing SO duties had completed the required competencies and training prior to being assigned as an SO.

The OIG found that for the inpatient medical unit, a moderate-risk work area, 11 (22 percent) of the 49 staff had not completed level I training, 16 (33 percent) had not completed or had expired level II training, and 24 (49 percent) had not completed or had expired level III training. Facility leaders failed to ensure that staff received this VHA required training to be prepared to identify and appropriately intervene to reduce risk of injuries to patients and self.

Issue 2: Patient's Level of Care

The OIG did not substantiate that the patient failed to receive an appropriate level of care at the Facility. The patient had both medical and MH conditions. Due to his medical conditions, he could not be admitted to a locked MH unit but was admitted to an open acute medical care unit with both medical and MH providers. He was placed on one-to-one observation for his safety.

Admission to a Medical Unit

The hospitalist[41] who admitted the patient deferred treatment of certain signs and symptoms to the psychiatry officer of the day, who was a PA. The psychiatry PA consulted with the attending psychiatrist regarding the patient and initiated appropriate treatment.

Interviewees were divided over the reasons for the patient's symptoms of agitation or restlessness. One of the patient's hospital psychiatrists attributed the behaviors to underlying medical and behavioral health conditions. Those who observed the patient regularly suggested that the patient's behaviors may have been related to being undesirably observed at close proximity for the duration of the hospitalization, being unable to smoke cigarettes at will, and not being allowed to go home.

According to an SO documentation, hours after admission, the patient stated that "I can't jump out of the window without a parachute." When interviewed, the SO stated this was reported to an RN at the time of the event. Another incident occurred during the same timeframe when the patient opened a window. The SO closed the window and told the patient that he was not permitted to open the window.

In interviews, three of eight medical providers acknowledged speaking with staff about the patient. One hospitalist did not recall any conversations with other physicians or nurses regarding the patient's agitation. However, in other interviews, there were multiple reports of contact between physicians to discuss various aspects of the patient's care.

During an interview with the psychiatrist who was supervising the resident, the OIG learned that the supervising psychiatrist did not see or examine the patient during the hospitalization. The supervising psychiatrist did have discussions with the resident regarding the patient's care.[42]

Facility staff who were interviewed said that the patient disliked the special observation status, was "upset about being watched," and just wanted to "go home." The nurses and SOs involved in the patient's care discussed an agitated, frustrated, or restless patient who was kind and not

[41] A hospitalist is a physician whose practice is generally limited to the treatment of hospitalized patients. The patients typically are under the care of another physician when they leave the hospital, most often the physician who provides them ongoing outpatient medical care.

[42] Chillicothe VA Medical Center Memorandum (MCM) 11A-02, *Resident Supervision*, June 13, 2016.

aggressive. One physician described the patient's behavior, on the day prior to death, as very happy and very talkative. Several of those interviewed believed that the patient was attempting to escape from the Facility's medical unit when he went through the window and fell to his death. The SO who was assigned to the patient at the time of his death was able to quickly open the locked bathroom door and follow the patient into the bathroom. The SO attempted to rescue the patient by grabbing him, but the patient slipped from the SO's grasp.

Information received during interviews with those involved in the care of the patient provided additional insight regarding the patient's hospital course. Most nurses and SOs stated that they believed the patient was not suicidal. The resident and psychiatrist who treated the patient during the 2017 hospitalization did not consider the patient to be suicidal. The hospitalists who provided medical care did not think the patient was suicidal. The psychiatrist who cared for the patient on an outpatient basis for nearly three years prior to the last admission did not believe the patient was suicidal when seen and evaluated in 2017.

According to the coroner's report, the patient's death was ruled accidental. The physician who documented the patient's discharge summary stated that he listed suicide as the primary discharge diagnosis because that was his opinion at the time based on the information available to him. He included his review of past hospitalizations and discharge diagnoses in arriving at this conclusion. However, after discussing the patient's care with others, he thought that the patient may have just been trying to get out of the building, through the window.

While the patient had medical conditions that may have been contributory to his death, they appear to have been adequately treated during this hospitalization. One hospitalist noted that the patient was unhappy with blood pressure medications and was unable to recall if the patient was refusing any of the five prescribed medications to treat blood pressure. Another hospitalist involved in the patient's care during the latter part of the hospitalization, believed that the patient's blood pressure elevation was related to the behavioral health symptoms. This physician believed that the patient's blood pressure was getting better. The patient's physicians attempted to transfer him to a behavioral health unit, but the transfer was denied by the receiving unit due to the patient's uncontrolled blood pressure. One physician interviewee, who was concerned that the patient's incompetence was related to an elevated ammonia level, was treating the elevated ammonia level with three medications.

Complicating the patient's medical and behavioral health problems, including one elopement attempt, were the patient's desire to go home, smoke cigarettes, and frustration with being observed at all times. The combination of the patient's health problems, frustration, the bathroom door that could be locked from the inside, and the bathroom window that could be fully opened to the outside all contributed to the patient's death.

Issue 3: Grief Counseling

The OIG determined that Facility staff offered grief counseling to the patient's available family and staff. According to the EHR, Facility staff made repeated efforts to offer grief counseling services to the decedent's family member who the patient had listed as his next-of-kin. The Facility spoke by telephone with the family member who declined grief counseling or resources.

The Facility provided crisis intervention for employees immediately following the patient's death through EAP counselors.[43] Employees were offered individual counseling to minimize the potential for long-term psychological harm or impact on work performance in accordance with Facility policy and Office of Personnel Management guidelines.[44] When asked, most staff reported grief counseling was offered. It remained available along with referrals as needed for ongoing MH care.

Issue 4: Other Findings—Institutional Disclosure and Notification of Next-of-Kin

The day of the event, a staff physician documented in a note titled "clinical disclosure," that he called the decedent's family member, who the patient had listed as his next-of-kin, to inform the family member of the patient's "unexpected death by suicide." The physician told the family member that the patient "jumped out of the window."

The next day, the Risk Manager, the Suicide Prevention Coordinator, and the Chief of Ambulatory Care & Processing documented that they called the family member to initiate a formal institutional disclosure. The Risk Manager provided an overview of the process and "offered the [family member] the opportunity to meet with a team to discuss the events surrounding the patient's death…." The family member declined a formal disclosure at that time but "reserved the right to call back and schedule a meeting in the future." The family member was provided with the Risk Manager's contact number for this purpose. Staff offered their condolences and furnished information regarding available bereavement support and the patient's burial benefits. The family member's questions were answered. A letter was mailed to the family member that day explaining the process required to file claims under 38 U.S.C., Section 1151 and the FTCA.

During the conversation with Facility staff, the family member identified an ex-spouse and an adult child, who had been estranged from the patient for many years. The family member reported having no contact with them for many years and was unaware of their whereabouts.

[43] Chillicothe VA Medical Center Memorandum (MCM) 116-04, *Employee Assistance Program*, July 29, 2016.
[44] MCM 116-04; OPM Guidelines, Federal Employee Assistance Programs, September 2008.

As of March 16, 2018, two other notes documenting interactions with the family member related to bereavement counseling had been entered in the EHR.

The OIG identified deficiencies in the Facility documented institutional disclosure as it did not include updated information related to the circumstances surrounding the patient's care at the Facility or the events leading to his death. The Facility has an ongoing obligation to report newly-acquired information and engage in a discussion of clinically significant facts to the patient's personal representative or next-of-kin.[45] The Facility did not attempt to locate the patient's adult child, who, while not listed as next-of-kin in the patient's EHR, would have a superior claim to pursue legal action than the family member who had been listed as next of kin.

Failure to report that the patient's death was deemed accidental rather than a suicide could have implications for the next-of-kin in determining whether to pursue a wrongful death claim under the FTCA. According to staff reports, the patient fell to his death while attempting to leave the Facility by climbing out the second-story bathroom window. VHA policy states the next-of-kin should be apprised of the facts as they emerge that may have contributed to the incident.[46]

[45] VHA Directive 1605.01, Section 5b (1)-(4) pages 18-22, August 31, 2016; VHA Handbook 1004.08, Section 8 pages 8-9.

[46] VHA Handbook 1004.08, Section 8 pages 8-9.

Conclusion

The OIG team substantiated that adequate security and safety measures were not in place for patients on the medical floor who might try to exit the Facility improperly. The windows on the inpatient medical unit were not secured or limited in width of opening at the time of the incident as required by VHA, nor identified as deficiencies during the AWE inspection process.

The physician's special observation order required the SO to keep the patient within eye sight, not at arm's length. The patient was able to close and lock the bathroom door before the SO could get to the door. The RN and SO documentation did not meet the content and frequency requirements detailed in the Facility policy.

Facility leaders failed to monitor staff compliance with SO documentation requirements that likely contributed to insufficient staff communication during patient handoffs. Training records indicated that numerous staff who worked on the unit did not have all required PMDB training, SO competencies, and SO training. Facility leaders' failure to ensure that staff performing SO duties were trained and competent likely contributed to staff being unaware of SO guidelines and duties, resulting in a safety risk to patients and staff.

The OIG did not substantiate that the patient failed to receive an appropriate level of care at the Facility. The patient had both medical and MH conditions. Due to his medical conditions, he could not be admitted to a locked MH unit but was admitted to an open acute medical care unit with medical and MH providers. He had orders for one-to-one observation for his safety.

The OIG found that appropriate grief counseling was offered by the Facility for staff and the patient's available family. Although the patient had an adult child, the adult child was estranged from the patient and the Facility contacted the family member who was listed as next-of-kin in the patient's EHR. Facility staff spoke by telephone with the family member who declined grief counseling or resources. The Facility provided crisis intervention for employees immediately following the patient's death through EAP counselors.

The family member was informed during the institutional disclosure that the patient committed suicide which was not subsequently supported in interviews or the coroner's report. The Facility failed in its ongoing obligation to report newly-acquired information and engage in a discussion of all clinically significant facts leading to the patient's death with the patient's personal representative or next-of-kin.

The OIG made four recommendations.

Recommendations 1–4

1. The Chillicothe VA Medical Center Director ensures that the windows of patient care areas remain secure in accordance with Veterans Health Administration Center for Engineering and Occupational Safety and Health guidelines.

2. The Chillicothe VA Medical Center Director makes certain that the Chillicothe VA Medical Center's policy for Special Observation is followed and monitors for compliance.
3. The Chillicothe VA Medical Center Director verifies that training and staff competencies are completed for Prevention and Management of Disruptive Behavior and Special Observation as required.
4. The Chillicothe VA Medical Center Director confers with the Office of Chief Counsel regarding the notification of the patient's death and discussion of institutional disclosure with the next-of-kin and takes action as appropriate.

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 2, 2018

From: Director, VA Healthcare System, Cincinnati, Ohio (10N10)

Subj: Healthcare Inspection—Inpatient Security, Safety, and Patient Care Concerns at the Chillicothe VA Medical Center, Ohio

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

1. Please find attached the comments and actions to be taken in response to the recommendations in the OIG report entitled, Inpatient Security, Safety, and Patient Care Concerns at the Chillicothe VA Medical Center.
2. I concur with the facility's response and appreciate the opportunity to respond to this report.

(Original signed by :)

Robert McDivitt, FACHE

Network Director

Appendix B: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: June 29, 2018

From: Director, Chillicothe VA Medical Center (538/00)

Subj: Healthcare Inspection— Inpatient Security, Safety, and Patient Care Concerns at the Chillicothe VA Medical Center, Ohio

To: Director, VA Healthcare System, Cincinnati, Ohio (10N10)

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled, Inpatient Security, Safety, and Patient Care Concerns at the Chillicothe VA Medical Center.
2. Please contact our facility for any additional questions or if further information is required.

(Original signed by:)

Mark Murdock, MHA, FACHE
Medical Center Director

Comments to OIG's Report

Recommendation 1

The Chillicothe VA Medical Center Director ensures that the windows of patient care areas remain secure in accordance with Veterans Health Administration Center for Engineering and Occupational Safety and Health guidelines.

Concur.

Target date for completion: September 19, 2018

Director Comments

Chillicothe VA Medical Center leadership implemented the action of securing all patient care area windows to improve patient and staff safety. The facility secured the windows in the Acute Medicine Unit on July 13, 2017. Effective September 28, 2017, all inpatient windows throughout the campus were secured in accordance with Veteran's Health Administration Center for Engineering and Occupational Safety and Health guidelines. All outpatient windows were secured in patient care areas in accordance with Veteran's Health Administration Center for Engineering and Occupational Safety and Health guidelines effective January 24, 2018. The facility will complete one audit in the next 90 days to ensure the windows in the patient care areas are secure and then twice per year in Environment of Care Rounds. Additional audits will occur in Leadership rounds, Quality/Safety tracers, VISN Annual Workplace Evaluation (AWE), and VISN Quality Safety visits to monitor compliance, ensuring no windows have been tampered with.

Recommendation 2

The Chillicothe VA Medical Center Director makes certain that the Chillicothe VA Medical Center's policy for Special Observation is followed and monitored for compliance.

Concur.

Target date for completion: October 1, 2018

Director Comments

Each Inpatient Nurse Manager will monitor staff sitting with special observation patients to ensure staff is following the policy regarding documentation and remaining within arm's reach of the Veteran, unless otherwise specified. The Special Observation order was updated July 21, 2017, Special Observation policy was updated on February 23, 2018, and the Special Observation template updated April 23, 2018. The Nurse of Day (NOD) monitored all Special Observation patient documentation from December 2017 through May 2018, just-in-time

training was provided to any staff member who had deficiencies. The facility also created a process for the Special Observation Plan/ Handoff Communication forms to be placed in the patient's electronic health record. The Nurse Managers will audit 100% of the Special Observation template notes and Special Observation Plan/Handoff Communication forms monthly to ensure required documentation is complete with a 95% compliance rate for three consecutive months. Nurse Managers will do random spot checks to ensure compliance with policy; the nurse manager will do just-in-time training for any deviation from policy. Quality Management will conduct random tracers to include review of practice and to ensure compliance with the policy. Tracer data will be reviewed every month with Nursing.

Recommendation 3

The Chillicothe VA Medical Center Director verifies that training and staff competencies are completed for Prevention and Management of Disruptive Behavior and Special Observation as required.

Concur.

Target date for completion: October 1, 2018

Director Comments

Each Nurse Manager is responsible for ensuring that the training and competency validation documentation is complete and specifies the method of the verification, the date of validation, and the signature of the evaluator and employee. The Inpatient Nurse Managers will monitor Prevention and Management of Disruptive Behavior (PMDB) Training monthly to ensure that all staff comply with the unit required level of PMDB training documented in TMS. The Inpatient Nurse Managers will ensure 100% of staff has completed the appropriate level of PMDB Training documented in TMS by August 1, 2018. The Inpatient Nurse Managers will ensure 100% of the staff have completed Special Observation competencies by August 1, 2018, with date of validation and signature of evaluator and employee. Any new hires will have PMDB training and Special Observation Training within 90 days of their start date. Staff will not be assigned Special Observation assignments until trainings have been completed and verified. The Nurse Managers will audit PMDB training and Special Observation Competencies to ensure 100% compliance rate for three consecutive months.

Recommendation 4

The Chillicothe VA Medical Center Director confers with the Office of Chief Counsel regarding the notification of the patient's death and discussion of institutional disclosure with the next-of-kin and takes action as appropriate.

Concur.

Target date for completion: October 1, 2018

Director Comments

The facility Risk Manager contacted the Office of Chief Counsel (OGC) regarding the notification of the patient's death and discussion of institutional disclosure with the next-of-kin. After this discussion, the OGC felt that Institutional Disclosure was provided to the available next of kin with updated information related to the circumstances surrounding the accidental death determined by the coroner. These discussions with the next of kin were documented in the reports of contact by the Risk Manager instead of addendums to the Institutional Disclosure note. The OGC suggested that a review of the record be completed to determine if any additional names of family members could be identified to assist with the whereabouts of the Veteran's estranged adult child since the adult child was not notified. The Risk Manager subsequently attempted to locate contact information for additional family members in the Veteran's record, without success. The facility has attempted reasonable and diligent efforts to identify the Veteran's estranged adult child to provide Institutional Disclosure without success.

OIG Contact and Staff Acknowledgments

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