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VETERANS HEALTH ADMINISTRATION

Inpatient Mental Health Clinical Operations Concerns at the Phoenix VA Health Care System

Arizona

HEALTHCARE INSPECTION | REPORT #17-02629-119 | MAY 7, 2019

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Executive Summary

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to allegations received or concerns identified in 2016 and 2017 related to the clinical operations of the inpatient mental health unit at the Phoenix VA Health Care System (facility), Arizona, specific to the subpopulation of patients admitted with a diagnosis of dementia. The allegations and concerns are listed below:

- Inappropriate admission of patients with dementia to the inpatient mental health unit
- Improper restraint of a patient because a seclusion room was unavailable
- Unmet needs of patients on the mental health unit
  - One-to-one care
  - Inadequate staffing
  - Lack of mental health training
    - Prevention and management of disruptive behavior
    - Seclusion and restraint
    - Dementia care
  - Failure to provide a therapeutic environment
    - Cleanliness
    - Interior updates
    - Personal clothing
    - Patient advocacy program
    - Psychotherapy

The OIG team did not substantiate the inappropriate admission of patients with dementia to the inpatient mental health unit. The admission criteria, "[s]ymptoms of suicidality, homicidally [*sic*] or grave disability due to a mental illness, which includes mood, anxiety, and thought disorders"[1] were broad *and* would include dementia as a qualifying diagnosis. However, *patients* with dementia may have markedly different care needs from other patients admitted to the inpatient mental health care unit; the facility frequently addressed the care needs of patients with dementia with the use of one-to-one observation. The OIG team found that patients with dementia admitted to the inpatient mental health unit had a longer length of stay when one-to-one

[1] *Facility Inpatient Psychiatry*: *Units 5C & 5D*, July 29, 2016.

observation for safety was required and that discharge planning for patients who were assigned one-to-one care may have been more difficult to coordinate if a receiving facility interpreted the one-to-one care requirement in the acute mental health unit as a continuing need after transfer.

The OIG conducted site visits in 2017 and 2018. During the first visit in 2017, the OIG team did not find specific programs for patients with dementia. During the second visit in 2018, the OIG determined that a geriatric psychologist with expertise in the care of patients with dementia had been hired and was developing programs and training specific to patients with dementia. Therefore, the OIG did not make a recommendation related to programming for patients with dementia admitted to the inpatient mental health unit.

While the OIG team substantiated one of the two facility seclusion rooms was unavailable for several weeks in 2017 due to an environmental issue, the OIG was unable to determine whether a patient was improperly restrained because a seclusion room was not available. The OIG team found that the one available seclusion room was occasionally used as a private room for acute mental health patients based on patient preference rather than patient need. To evaluate this issue further, the OIG team reviewed the electronic health records (EHRs) of all six patients who had been placed in restraints and/or seclusion between January 1, 2017, through April 30, 2017. The OIG did not find evidence in the EHRs that patient care needs were negatively impacted due to the unavailability of a seclusion room. At the time of the team's 2018 visit, the second seclusion room was available for patient use.

During its review of the six patients' EHRs, the OIG identified deficiencies related to consistent documentation of clinical justification for the continued use of restraints and debriefing sessions for the patient, staff, and family members after a restraint episode.

The OIG substantiated that inpatient mental health unit staff did not consistently follow the facility's patient safety observer (PSO) policy that outlined one-to-one care.[2] The OIG reviewed 16 patient cases with 315 incidents of one-to-one care during January 2017, and found PSO to patient ratios were not one-to-one, PSOs did not maintain constant visual observation of patients, and documentation was inconsistent.

The OIG was unable to determine whether nurse staffing was adequate to meet patient care needs. The staffing methodology documents that the facility provided in 2017 for the inpatient mental health unit were not complete and did not include PSOs who were assigned to mental health patients and assisted with patient care.[3] At the time of the 2018 OIG visit, the inpatient mental health unit was separated into two distinct units (5C and 5D). Patients with dementia were admitted to 5D (and not 5C). A geriatric psychologist was hired in September 2017 and

[2] Facility Policy 118-10, *Patient Safety Observer*, April 30, 2015.

[3] VHA Directive 2010-034, *Staffing Methodology for VHA Personnel*, July 19, 2010. This directive was in effect at the time of the events discussed in this report; it was rescinded and replaced by VHA Directive 1351, *Staffing Methodology for VHA Personnel*, December 20, 2017; Facility Policy 118-10.

assigned to 5D. The staffing methodology documents provided in 2018 did not include supporting data used to determine nursing hours per patient day after the inpatient mental health unit was separated into two distinct units.

The OIG substantiated that some staff who worked on the inpatient mental health unit did not have required annual training identified by the facility's Workplace Behavioral Risk Assessment in accordance with the facility's policy that was issued in 2012 and was current at the time of the events discussed in this report. Facility managers informed OIG inspectors in 2018 that they had adopted a two-year competency skills assessment requirement (the Acting Deputy Under Secretary for Operations and Health had approved a two-year requirement in 2013) although the 2012 facility policy indicated annual training was required. In June 2018, the facility rescinded the 2012 policy and officially adopted the two-year competency skills assessment requirement.

In 2017, the OIG team substantiated that the inpatient mental health unit was not a therapeutic environment due to the absence of cleanliness and interior updates, patients not wearing personal clothes, and a noncompliant patient advocacy program. In 2018, the OIG team noted a satisfactory improvement in the cleanliness after the facility contracted with an external company that provided cleaning services.

While the availability of clinicians who could provide psychotherapy in the unit was low for several months around the time of the OIG's first visit, the Section Chief of Psychology was available during that time frame to make recommendations when necessary for outpatient psychotherapy. Additionally, a geriatric psychologist was scheduled to join the inpatient mental health staff in the fall of 2017 and was present during the second site visit. Therefore, the OIG did not make a recommendation related to availability of psychotherapy on the inpatient mental health unit.

The OIG made seven recommendations related to documentation issues, the patient safety observer policy, staffing methodology, training of mental health staff, environment of care, and the patient advocacy program.

Comments

The Veterans Integrated Service Network and System Directors concurred with the OIG's recommendations and submitted acceptable action plans. (See Appendixes A and B, pages 26–33 for the comments.) The OIG considers recommendations 2, 3, 5, and 7 closed and will follow up on the planned actions for the remaining recommendations until they are completed.

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Contents

Abbreviations

CLC	community living center
CMS	Centers for Medicare and Medicaid Services
EBP	evidence-based psychotherapy
EHR	electronic health record
FY	fiscal year
LIP	licensed independent practitioner
NHPPD	nursing hours per patient day
OIG	Office of Inspector General
PMDB	Prevention and Management of Disruptive Behavior
PSO	patient safety observer
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Introduction

The VA Office of Inspector General (OIG) conducted a healthcare inspection in response to allegations received in 2016 and 2017 related to the clinical operations of the inpatient mental health unit specific to the subpopulation of patients admitted with a diagnosis of dementia at the Phoenix VA Health Care System (facility), Arizona.[4]

Background

The facility, composed of the Carl T. Hayden Veterans Affairs Medical Center and seven clinics, is part of Veterans Integrated Service Network (VISN) 22. VA classifies the facility as a Level 1b—high complexity facility.[5] In fiscal year (FY) 2017, the facility served 91,424 patients and had a total of 294 hospital operating beds, including 166 in-patient beds, 104 community living center (CLC) beds, and 24 domiciliary beds.

Veterans Health Administration Services for Patients Diagnosed with Dementia

Dementia is a symptom complex characterized by intellectual deterioration (including disturbances in memory as well as language, spatial abilities, impulse control, judgment, or other areas of cognitive ability) severe enough to interfere with social or occupational functioning. VA has established three different types of units to provide specialized inpatient services for veterans with dementia:

(1) Diagnostic units focus on short-term behavioral stabilization, plan of intervention, differential diagnosis of dementia, and discharge placement with an anticipated length of stay up to 30 days.

(2) Behavioral units focus on treatment of patients with dementia experiencing physical and/or significant behavioral problems in addition to discharge placement with an anticipated length of stay 30–90 days.

[4] While the OIG 2017 engagement letter stated that the inspection was related to the clinical operation of the acute care mental health unit, facility leaders subsequently told OIG staff that they were not clear about the purpose of the first visit and expected a review of human resource issues.

[5] The VHA Facility Complexity Model categorizes medical facilities based on patient population, clinical services offered, educational and research missions, and administrative complexity. Complexity Levels include 1a, 1b, 1c, 2, or 3, with Level 1a facilities being the most complex and Level 3 facilities being the least complex.

(3) Long-term Care units focus primarily on patients in the later stages of their dementing illness by providing comfort and supportive care.[6]

According to Veterans Health Administration (VHA) policy, these services can be provided either within Mental Health Services or on a specialty unit within a VA CLC.[7] In 2017, the facility did not have a specialty unit for patients with dementia. Patients with dementia were admitted to the facility's inpatient mental health unit, 5C/5D, until discharged to an appropriate location.

VHA defines acute mental health care as high-intensity mental health services for patients with severe emotional and/or behavioral symptoms that are acute, resulting in severely compromised functional status and/or causing a safety risk to self or others. This level of care is typically provided in an inpatient setting, which allows the type and intensity of clinical intervention necessary to treat the patient and ensure safety.[8]

A goal of inpatient mental health services is the provision of evidence-based, recovery-oriented care in a safe, healing environment. VHA requires that recovery-oriented, interdisciplinary programming is available on the inpatient mental health unit for a minimum of four hours every day including weekends and holidays. Services are provided in partnership with patients and their families, and address the goals of recovery, rehabilitation, improved quality of life, and community integration.[9]

The facility's July 2016 qualifying diagnosis/criteria for admission to its inpatient mental health unit were "[s]ymptoms of suicidality, homicidally [*sic*] or grave disability due to a mental illness, which includes mood, anxiety, and thought disorders. Medical clearance is necessary prior to admission to the Inpatient Psychiatric [mental health] Units."[10] The criteria would include patients with dementia.[11]

Seclusion and Restraints

VHA policy outlines specific requirements related to the use of seclusion and restraints in an inpatient mental health unit:

[6] Geriatrics and Extended Care. *Dementia Care (including Alzheimer's*), https://www.va.gov/GERIATRICS/Alzheimers_and_Dementia_Care.asp. (This website was accessed on November 2, 2017.)

[7] Geriatrics and Extended Care. Dementia Care (including Alzheimer's).

[8] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

[9] VHA Handbook 1160.06.

[10] *Facility Inpatient Units 5C & 5D*, July 29, 2016.

[11] At the time of the OIG's second visit in March 2018, the mental health unit was separated into two units with distinct staff and types of patients. Patients with dementia diagnoses were being admitted to 5D and not 5C.

- Seclusion and restraints are interventions of last resort and only for patients whose behavior presents an imminent risk to self or others and nonrestrictive interventions have not eliminated the risk.
- Inpatient units must continually explore ways to prevent, reduce, and eliminate seclusion and restraints usage.
- Clinical programming, staffing levels, activities and staff engagement with patients must facilitate a staff's ability to identify issues and intervene before a patient reaches a level of agitation or safety risk that requires seclusion or restraints.
- Staff must be trained and competent to provide de-escalation and interventions to prevent a patient from reaching a level of agitation or risk that requires seclusion or restraints.
- Staff must be trained and competent in the use of seclusion and restraints including the use of specific devices used for restraints on their unit.
- Every inpatient unit must have at least one room designed and designated for seclusion and restraints. The room must be structured to prevent patient self-injury while retaining a therapeutic ambiance through color, lighting, noise control, and an appropriate bed.
- Use of seclusion or restraints must be terminated as soon as it is safe to do so. Assurance of staff safety must be a consideration whenever seclusion and/or restraints are no longer necessary.[12]

The facility policy for the use of seclusion and restraints is not specific to the inpatient mental health unit but applies to patients in all units. Similar to VHA policy, the facility policy indicates that seclusion and restraint interventions are to be used only when nonphysical interventions fail or when an imminent and significant safety risk demands an immediate physical response. The facility policy outlines specific treatments:

- Seclusion is the involuntary confinement of a person in a locked room.
- Restraint is the direct application of physical force to an individual, without the individual's permission, to restrict his/her freedom of movement. The physical force may be human, mechanical devices such as straps connected to a bed, or a combination.

[12] VHA Handbook 1160.06.

- Behavioral health care indications for the use of restraints are primarily to protect individuals against injuring themselves or others because of an emotional or behavioral disorder in the acute or behavioral health setting.[13]

Facility policy requires a clinical assessment and medical justification before the use of seclusion or restraints.[14] A registered nurse (RN) may initiate seclusion or restraints but a physician or licensed independent practitioner (LIP) must be notified and authorize such use within an hour.[15] Once implemented, the intervention must be documented in the electronic health record (EHR) and the patient's status must be documented every 15 minutes on a flowsheet that is subsequently scanned into the EHR. An RN assesses the need for seclusion or restraints every two hours. A physician or LIP assesses the need every four hours. The seclusion/restraints are discontinued when the patient no longer exhibits behavior that is a danger to self or others. Staff involved in seclusion or restraint interventions must conduct a debriefing session with the patient or the appointed family members within 24 hours of discontinuing the intervention.[16]

Inpatient Mental Health Services Needs

One-to-One Care

The facility's 2015 patient safety observer (PSO) policy established guidelines for patients requiring one-to-one care.[17] A PSO is a nursing assistant, behavioral health technician, or nurse who is assigned the specific duties of constant visual monitoring of a patient for safety; the PSO may also assist in checking vital signs and providing activities of daily living.[18]

The facility's policy states that an LIP "will write an order and document the appropriate level of observation status in the patient's medical records." A one-to-one PSO/patient ratio may be ordered for patients presenting with conditions including but not limited to expressed suicidal or

[13] Facility Policy 11-71, *Restraint and Seclusion*, August 13, 2013. Facility Policy 11-71, *Restraint and Seclusion,* August 13, 2013, was in effect until March 1, 2017, when it was rescinded and replaced with Facility Policy 11-71, *Restraint and Seclusion,* March 1, 2017. The policies contain similar language concerning the use of behavioral restraints.

[14] Facility Policy 11-71.

[15] Facility Policy 11-71.

[16] Facility Policy 11-71.

[17] Facility Policy 118-10, *Patient Safety Observer*, April 30, 2015.

[18] Facility Policy 118-10; VHA Handbook 1170.04, *Rehabilitation Continuum of Care,* December 30, 2014. Activities of daily living refers to specific personal care activities or tasks required for daily maintenance and sustenance such as grooming, bathing, dressing, personal hygiene, toileting, eating, and mobility.

homicidal ideation, confusion, poor judgment, or posing a safety concern for self-injury such as patients who are at risk for falls.[19]

For patients on one-to-one observation, the PSO must constantly attend and observe the patient. For patients on one-to-one suicide watch protocol, the PSO must be within arm's reach of the patient.[20]

The facility policy also requires that PSOs receive orientation to the unit and assigned role as well as training in the skills necessary to perform the duties.[21] The unit charge nurse provides orientation verbally to the PSO upon his/her assignment.[22] Written guidance on the unit should be read prior to the employee's first assignment as a PSO. The PSO must document patient behaviors every 15 minutes on the required flowsheet.[23] The nurse manager ensures ongoing re-assessment for continuation of one-to-one orders and that an LIP enters an order for continued one-to-one care every 24 hours.[24]

Staffing Methodology[25]

Staffing methodology is the process used to ensure appropriate levels of direct patient care staff are available at all points of care. The process includes numerous factors for patient care needs such as patient acuity and the skill level of staff needed to provide the care; it also evaluates whether the current nursing hours per patient day (NHPPD) are sufficient to meet all patient care

[19] Suicidal ideation is defined as any self-reported thought of self-inflicted injury with the intent to die. Facility Policy 122-19, *Suicide and Suicide-Related Behavior,* November 15, 2014. Homicidal ideation is any self-reported thought of ending the life of another individual. https://www.merriam-webster.com/dictionary/homicidal. (The website was accessed on October 24, 2018.); Facility Policy 118-10.

[20] Facility Policy 122-19.

[21] Facility Policy 118-10.

[22] Facility Policy 118-10.

[23] Facility Policy 118-10.

[24] Facility Policy 118-10; "Licensed Independent Practitioner is defined as an individual, as permitted by law and regulation, and also by the organization, to provide care and services without direction or supervision within the scope of the individual's license and consistent with the privileges granted by the organization." The Joint Commission document "Ambulatory Care Program: The Who, What, When, and Where's of Credentialing and Privileging." https://www.jointcommission.org/assets/1/18/AHC_who_what_credentialing_booklet.pdf.

[25] VHA Directive 2010-034, *Staffing Methodology for VHA Personnel*, July 19, 2010. This directive was in effect at the time of the events discussed in this report; it was rescinded and replaced by VHA Directive 1351, *Staffing Methodology for VHA Personnel*, December 20, 2017. While the 2010 directive required a full staffing methodology process annually, the 2017 directive states that the full process "must be conducted at least every two years." The 2017 directive continues to require a review of the Staffing Plan annually and states that a full process may be triggered more frequently than every two years, by certain events (for example, significant changes, addition of a specialist to a unit).

needs based on nursing activities.[26] According to the VHA staffing methodology directive that was current at the time of the OIG's 2017 visit, the process was to be completed annually.

VHA outlines the steps required when determining appropriate levels of nursing staff (numbers and skill level) at all points of care based on each staff member's direct care responsibilities. These responsibilities do not include tasks performed by one-to-one observers unless the observers are assisting patients with their activities of daily living.[27] At the facility, PSOs were assigned as one-to-one observers on the inpatient mental health unit and provided activities of daily living care to patients with dementia; therefore, the OIG concluded that PSOs should be included in the unit staffing methodology.[28]

Mental Health Staff Training

Mental health is a specialty area that requires specific training to prevent harm to staff and patients. Specific training requirements include prevention and management of disruptive (PMDB) behavior and seclusion and restraints.[29]

Prevention and Management of Disruptive Behavior

Per facility policy issued in 2012, PMDB training must be completed by all employees within 90 days of hire (Level 1) and annually thereafter, depending upon an employee's workplace risk level (Levels II–IV).[30] The employee Threat Assessment 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 (for example, the inpatient mental health unit) in the previous year. [31] A disruptive behavior is behavior by an individual that is intimidating, threatening, or dangerous that could jeopardize the health or safety of patients, employees, or individuals at the facility.[32]

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[26] The phrase "nursing hours per patient day" is the total number of nursing hours of care available divided by the number of patients, in a 24-hour period. NHPPD is a nurse staffing ratio proxy and can be proportioned by skill mix and shift distribution. VHA Directive 1351.

[27] VHA Directive 1351.

[28] VHA Directive 1351, Appendix B, lists specific groups of nursing staff that should be included and excluded from NHPPD calculations. One-on-one (1:1) sitters, whose only role is to observe patients were excluded. Nursing assistants and patient care health technicians were included. The 2017 directive specifically includes "[s]itters performing direct patient care (in proportion with their direct care assignment)."

[29] VHA Handbook 1160.06.

[30] Facility Policy 00-32, *Workplace Safety and Facility Behavioral Response Programs*, December 20, 2012.

[31] Acting 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 Behavior (PMDB) Curriculum," November 7, 2013; Facility Policy 00-32.

[32] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

The 2012 facility policy required Level II PMDB training for staff assigned to low, moderate, and high-risk work areas; Level III training for staff assigned to moderate and high-risk work areas; and Level IV training for staff assigned to high-risk work areas.[33] The 2012 facility policy also stated that, "[s]upervisors will assign and ensure employees complete annual PMDB training based on the risk level suggested by severity and frequency of behavioral incidents in the Annual Workplace Behavioral Risk Assessment."[34] The facility mental health unit is designated as a high-risk work area.

VHA Handbook 1160.06, issued in September 2013, provided guidance on mental health staff who required training:

> All staff who interact with patients on the inpatient mental health unit, including staff who provide services intermittently, such as phlebotomists, dieticians, speech therapists, chaplains, engineering and maintenance staff, and others, must receive annual training on the environment of care, the management of disruptive behavior, and gender-sensitive care.[35]

In November 2013, the Acting Deputy Under Secretary of Health for Operations and Management issued a memo that stated employees must demonstrate competency in the assigned PMDB skills every two years or retake the training.

> Skill assessment and retraining will occur...[e]mployees assigned to additional levels of PMDB training must undergo biennial skills assessments by certified PMDB facility trainers to evaluate competency. Employees unable to pass the skills assessment will repeat that level of training. TMS administrators will work with PMDB coordinator to accomplish reassignment to training levels as needed.[36]

On June 6, 2018, facility managers updated the 2012 facility policy to reflect a biennial competency skills assessment requirement.

[33] Facility Policy 00-32.

[34] Facility Policy 00-32.

[35] VHA Handbook 1160.06. Within the context of this report, the OIG team reviewed PMDB training records of the following facility mental health staff assigned to the unit that were provided by the facility: nurses, psychiatrists, social workers assigned to the unit, pharmacists, physician assistants, medical support assistants, and nursing staff who worked intermittently on the unit including nursing assistants, licensed practical nurses, and RNs.

[36] Acting Deputy Under Secretary for Health for Operations and Management Memorandum, November 7, 2013.

Seclusion and Restraints

VHA requires that staff be trained and competent in the techniques to prevent the need for, as well as in the utilization of, seclusion or restraints.[37]

Per facility managers, nursing staff assigned to the mental health inpatient unit were expected to complete seclusion and restraints training annually. The facility's seclusion and restraint training consists of a pre-test, a PowerPoint presentation detailing proper use, a post-test to validate learning, skills check in the seclusion room, and a Talent Management System module called "Care of Patients in Restraints." [38]

Dementia Care

In January 2015, the VISN 18 Geriatrics and Extended Care Program Manager made a site visit to the facility and provided a report with recommendations for improvement. The VISN 18 team recommended mental health staff be included in dementia specific training when it was provided to CLC staff. The facility provided opportunities for the Centers for Medicare and Medicaid Services (CMS) Hand in Hand dementia training to the CLC and mental health staff.[39]

Therapeutic Environment

Cleanliness

VHA requires the environment of care to be maintained in a safe, clean, and functional manner for patients, their families, visitors, and employees.[40] The facility director is ultimately responsible for meeting the policy requirements.[41] Patients, families, and other stakeholders often base their impression of the quality of care upon a facility's appearance and cleanliness.[42] As VHA has noted "[t]he effectiveness of EMS operations [Environmental Management Services] directly impacts the image of VHA medical facilities."[43] The facility director is responsible for

[37] VHA Handbook 1160.06.

[38] The Talent Management System is the program VA uses to manage employee learning processes including deploying course content, course examinations, auditing, and reporting of course completion statistics. VA Learning University document "Introduction to VA TMS for all Administrators and Help Desk and Reports Managers."

[39] CMS Hand in Hand Dementia training consists of six modules that train individuals who work in nursing homes how to care for residents with dementia and prevent abuse. VHA implemented this training in CLCs in 2015.

[40] VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.

[41] VHA Directive 1850, *Environmental Programs Service*, November 4, 2011. This VHA directive was scheduled for re-certification on or before the last working day of November 2016 but has not been updated.

[42] VHA Directive 1850.

[43] VHA Directive 1850.

ensuring the implementation of the healthcare environment program functions associated with the environmental management service to ensure a safe, sanitary, healing environment.[44]

Interior Updates

In 2010, VHA issued a Mental Health Facilities Design Guide to assist facilities in creating a more patient-centered environment to support elements of treatment, and required that units bring about an experience of hopefulness, healing, and recovery while ensuring patient safety.[45] "The setting must be comfortable, reflecting a healing, home-like therapeutic setting."[46] This type of environment is promoted with the use of an open and bright design, visual and physical access to nature, in-door areas with natural light, wall colors, trims, accent colors, and securely anchored artwork.[47]

Personal Clothing

As part of a recovery-oriented environment, patients must be permitted to dress in personal clothing during the day as it promotes dignity and encourages recovery. Clothing items must be made available to patients who do not have access to their own clothes.[48]

Patient Advocacy Program[49]

A Patient Advocacy Program is established at each facility to assist patients and their families in the resolution of complaints and concerns. VHA policy outlines specific requirements that patients have easy access to someone who will hear their complaint:

> (1) The Patient Advocate Program is clearly identified for inpatients and outpatients, including information on who, where, when, and how to contact a patient advocate. The medical center's complaint and compliment reporting processes must be clearly identified. The telephone number of the Service-level Advocate (if applicable) as well as the facility or Medical Center Patient Advocates must be posted in all Inpatient Units, Outpatient Clinic areas, and other applicable (high-traffic) areas throughout the facility.

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[44] VHA Directive 1850.

[45] *Department of Veteran Affairs Office of Construction & Facility Management Design Guide,* December 2010, revised April 2014, and December 2017. The December revision did not address items under discussion in this report.

[46] VHA Handbook 1160.06.

[47] Department of Veteran Affairs Office of Construction & Facility Management Design Guide.

[48] VHA Handbook 1160.06.

[49] VHA Handbook 1003.4, *VHA Patient Advocacy Program*, September 2, 2005. This handbook was rescinded and replaced by VHA Directive 1003.4 *VHA Patient Advocacy Program*, February 7, 2018. The 2018 directive also requires the posting of Patient Advocate information in "all inpatient units, outpatient clinics, and other high-traffic areas throughout the facility."

> (2) Patient Rights and Responsibilities must be posted along with the availability of the Patient Advocacy Program, as well as a copy provided to patients at the time of admission to the facility.[50]

VHA defines the patient advocate as an employee who is specifically designated to manage the complaint process, including resolution, data capture, and analysis of issues/complaints. VHA policy states that "[t]he service-level advocate is an employee designated at the service level or point of service who assists front-line staff in resolving issues."[51]

The patient advocate tracking system (PATS) is an electronic system of record for documenting and tracking patient complaints to support patient advocate responsibilities. VHA's goal is for all complaints to be entered into PATS for tracking purposes and requires the service-level advocate to listen to complaints, work to resolve them, and enter this information into PATS. Complaints entered in PATS enable a comprehensive understanding of patient issues and concerns as well as the ability to analyze and trend patient complaints for performance improvement efforts.[52]

Psychotherapy

VHA requires patients on an inpatient mental health unit to have access to evidence-based psychotherapy (EBP) and treatments. Based on the location of the mental health unit, the availability of staff, and individual patient needs, treatment may be provided on or off the unit. EBP services must be provided by EBP trained and certified providers to all inpatients as needed.[53] Inpatient mental health programs for dementia patients would not generally include EBP services.

Past Site Visits

In July 2014, the Offices of Mental Health Operations and Mental Health Services conducted a consultative site visit at the facility. A report of the visit outlined areas for concern. Facility leaders developed an action plan to address the concerns. After visiting the unit, the OIG reviewed the 2014 report and action plan and found concerns identified in the report that had not been addressed.

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[50] VHA Handbook 1003.4. VHA Directive 1003.4 does not include the requirement that a copy be provided to the patient at the time of admission.

[51] VHA Handbook 1003.4 required that the service-level advocates have access to PATS in order to enter information and fully utilize the system. VHA Directive 1003.4 states: "[a] patient advocate or service level advocate must enter a Report of Contact (ROC) in the patient advocate tracking system that consists of all contacts that have an issue to be solved. ROCs need to be resolved and closed within 7 business days."

[52] VHA Handbook 1003.4

[53] VHA Handbook 1160.06.

In January 2015, the VISN 18 Geriatrics and Extended Care Program Manager made a site visit to the inpatient mental health unit. Facility executive staff requested the site visit to evaluate an allegation related to geriatric-aged patients and a need for a geriatric psychiatric unit. The OIG reviewed the report and found recommendations regarding dementia care on the inpatient mental health unit that were not addressed.[54]

Allegations

In June 2016 and March 2017, the OIG Hotline Division received allegations concerning the clinical operations of the inpatient mental health unit at the facility. During the inspection, the OIG team identified a concern regarding the provision of psychotherapy. The specific allegations and concerns are listed below:

- Inappropriate admission of patients with dementia to the inpatient mental health unit
- Improper restraint of a patient because a seclusion room was not available
- Unmet needs of patients on the mental health unit
    - One-to-one care
    - Inadequate staffing
    - Lack of mental health training
        - Prevention and management of disruptive behavior
        - Seclusion and restraint
        - Dementia care
    - Failure to provide a therapeutic environment; specifically, issues were identified in the following areas:
        - Cleanliness
        - Interior updates
        - Personal clothing
        - Patient advocacy program
        - Psychotherapy

[54] VISN Geriatrics and Extended Care site visit report.

Scope and Methodology

The OIG team initiated an inspection in April 2017, and conducted site visits May 8–10, 2017, and March 7–9, 2018. The OIG team reviewed relevant VA, VHA, and facility policies and procedures.

The OIG team requested and reviewed incident reports, root cause analyses, patient complaints, tort claims, administrative investigative board reports, emails concerning mental health unit issues, staffing logs, assignment sheets, staffing methodology documents provided by the facility, training records, and selected patients' January 1, 2017, through April 30, 2017, EHRs.

To evaluate the use of restraints and seclusion, the OIG team queried the Corporate Data Warehouse database for all patients with orders for restraints and seclusion between January 1, 2017, through April 30, 2017.[55] The OIG team requested that the facility provide the daily census sheets that identified patients in restraints or seclusion for the same period of time. The facility results matched the OIG results.

To evaluate staff training in 2017, the OIG requested a list of staff assigned to the inpatient mental health unit including intermittent employees and consultants (for example, physicians and pharmacists) and records of their training as required by VHA and the facility. The OIG requested additional information related to staff mental health training in 2018.

In 2017, the OIG team performed rounds of the inpatient mental health unit on two occasions. In 2018, the OIG team also performed rounds of the inpatient mental health unit.

In 2017, the OIG team interviewed the following staff: Facility Director, Associate Director of Patient Care Services, Section Chief of Inpatient Psychiatry, the nurse manager who was in charge of the inpatient mental health unit (5C/5D), assistant nurse managers, social workers, the psychologist assigned to the outpatient clinic, psychiatrists, physician assistants, registered nurses, licensed vocational nurses, nursing assistants, medical support assistants, and the Utilization Management Program Registered Nurse.

In 2018, the inpatient mental health unit was separated into two distinct units (5C and 5D). The OIG team interviewed the newly appointed nurse managers for both sections, the Facility Director, the Acting Associate Chief Nurse for Mental Health, the Section Chief of Inpatient Psychiatry, and the Associate Director of Patient Care Services.

[55] "VHA's Corporate Data Warehouse (CDW) is a national repository comprising data from several VHA clinical and administrative systems. The objective of CDW is to facilitate reporting and data analysis at the enterprise level by incorporating data from multiple data sets throughout the VHA into one standard database structure. CDW provides data and tools to support management decision making, performance measurement, and research objectives." This information is quoted from an internal VHA website that is not available to the public.

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 place. The OIG is unable to determine whether an event or action took place when there is insufficient evidence.

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.

Inspection Results

Issue 1: Alleged Inappropriate Admission of Patients with Dementia to the Inpatient Mental Health Unit

The OIG did not substantiate that patients with current or historical documentation of known or suspected dementia were inappropriately admitted to the inpatient mental health unit. Admission criteria included patients with "[s]ymptoms of suicidality, homicidally [*sic*] or grave disability due to a mental illness, which includes mood, anxiety, and thought disorders."[56] The criteria included patients with dementia as long as the patient was medically cleared prior to admission.[57] However, patients with dementia may have markedly different care needs from other patients admitted to the inpatient mental health care unit; the facility frequently addressed specific care needs of patients with dementia by using one-to-one observation.

A total of 371 patients were admitted to the acute mental health unit from January 1, 2017, through April 30, 2017. Of these, 20 had diagnoses of dementia or neurocognitive disorder.[58] Due to safety concerns for the generally frail, elderly patients with dementia, providers frequently ordered one-to-one observation to avoid injury from other patients who may become agitated and disruptive. Discharge planning for patients who were assigned one-to-care care could be difficult to coordinate if a receiving facility interpreted the one-to-one requirement in the acute mental health unit as a continuing need after transfer.

The OIG reviewed the lengths of stay for the 20 patients and determined that the average length of stay was 22 days, with care spanning from 1–112 days; one patient admitted during our study period was still receiving inpatient care as of August 15, 2017. Two of the 20 patients had repeat admissions.

Per VHA policy, services must be available on inpatient units consisting of "psychosocial and behaviorally-based interventions for geriatric patients, frail elderly, or patients with challenging behavior secondary to dementia…"[59] The OIG was told that patients with dementia were not receiving therapy specific to their mental health needs while on the inpatient mental health unit. The OIG team noted that group therapies reportedly offered by the facility at this time included nurse-led recovery skills training and nutritional classes, which did not appear to be specific to the needs of patients with dementia. The OIG also noted that a geriatric psychologist, a specialist

[56] *Facility Inpatient Psych Unit 5C 5D Admission Criteria.*

[57] Through staff interview and review of select patient EHRs, the OIG found mental health patients were evaluated by the Emergency Department physician who called the psychiatrist on call for the day for admission.

[58] Neurocognitive disorder is a group of disorders with acquired impairments in mental processes, including dementia. Dementia and neurocognitive disorder are interchangeable terms per the Diagnostic and Statistical Manual Fifth edition (DSM-5), although some dementias are considered to be subsets of neurocognitive disorder. In this report, when referring to patients with dementia, the OIG includes those with either diagnosis.

[59] VHA Handbook 1160.06.

in the treatment of elderly patients with mental, emotional and physical problems, (although not required to be on staff) was hired in April and entered on duty in September 2017. Because the OIG was unable to determine whether patients with dementia were undergoing therapy specific to their needs at the time of its 2017 visit, and a specialist was hired in September 2017 and interviewed during the second visit, the OIG did not make a recommendation on this matter.

Issue 2: Alleged Improper Restraint of a Patient

While the OIG team substantiated one of the two facility seclusion rooms was unavailable for several weeks in 2017 due to an environmental issue, the OIG was unable to determine whether a patient was improperly restrained because a seclusion room was not available. The OIG reviewed the EHRs of six patients who had a total of seven episodes of seclusion and restraints use during a specific time frame. The OIG did not find evidence in the EHRs that unavailability of seclusion rooms interfered with the care of the identified patients. During the review of the patients' EHRs, the OIG team identified deficiencies in documentation related to the continued use of restraints and debriefing sessions.

Use and Availability of Seclusion Rooms

In May 2017, the inpatient mental health unit (5C/5D) was a combined 48-bed unit with two designated seclusion rooms (5C-507 and 5D-519) and two private rooms that could be used as alternate seclusion rooms.[60] The remaining patient rooms contained two, three, or four beds. At the time of the OIG's first site visit in May 2017, one of the facility's two designated seclusion rooms had been unavailable for patient use due to environmental issues for several weeks.

Acute mental health unit staff are trained to evaluate patient behaviors and take measures to calm the patient (de-escalate) if the patient begins to manifest disruptive or unsafe behaviors. If de-escalation measures are unsuccessful, other measures, including seclusion or restraints, may be necessary.

One calming practice staff utilized was quiet-time or time out.[61] Quiet-time could be initiated by the patient voluntarily or by staff. During rounds on the unit and through EHR reviews, the OIG found that a common practice was to use one of the two seclusion rooms for extended periods of time for quiet-time. The OIG also found that a patient might remain in the seclusion room after

[60] In late 2017, the facility separated the combined unit into two distinct units.

[61] Facility Policy 11-71, *Restraint and Seclusion*, March 1, 2017; Facility Policy 11-71, *Restraint and Seclusion*, August 13, 2013. Per the facility's 2013 and 2017 policies, quiet time is the removal of the patient from the immediate environment to a quiet area that is not locked to help the individual gain emotional control. The 2017 policy included a 30-minute timeframe for quiet time.

an order for seclusion was terminated or quiet-time had ended due to patient preference for a private room.[62]

The use of a seclusion room for nonseclusion purposes could prevent ready access to the room when a seclusion room was needed urgently for another patient. The facility policy did not address procedures of seclusion or restraint for alternative locations or methods when a seclusion room was not available. If necessary, staff would relocate or isolate patients by using one of the two private rooms or a two- to four-bed room for the use of a single patient; these rooms were not properly equipped to place patients in for seclusion or restraints.

The OIG was informed about a patient who had escalating agitation and urgently needed a seclusion room. A patient who did not have orders to be in seclusion or quiet-time was reportedly in the one available seclusion room. To evaluate this issue further, the OIG team reviewed the EHRs of all six patients (with a total of seven incidents) who had been placed in restraints and/or seclusion between January 1, 2017, through April 30, 2017. The OIG did not find evidence in the EHRs that patient care needs were negatively impacted due to unavailability of a seclusion room. At the time of the team's 2018 visit, the facility had resolved the environmental issues and the second seclusion room was again available.

Documentation Issues

During a review of the identified patients' EHRs noted above, the OIG team identified deficiencies in documentation related to the continued use of restraints and debriefing sessions.

Continued Use of Restraints

Facility policy requires nursing staff to document that restraints are discontinued at the earliest possible time.[63] Staff entered information for the seven episodes onto the Individual Seclusion and/or Restraint Flowsheet that had been scanned into the EHRs; however, appropriate clinical justification for the continued use of restraints in three out of the seven episodes was not documented.

Documentation of Debriefing

Debriefing sessions were not documented for three of the seven episodes of restraint use. Of the remaining four, two were documented outside the required time frame; two were documented within the required time frame.[64]

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[62] Facility Policy 11-71, *Restraint and Seclusion*, March 1, 2017; Facility Policy 11-71, *Restraint and Seclusion*, August 13, 2013.

[63] Restraints may be terminated when the patient meets behavioral criteria, can follow directions, and cooperate with staff. Facility Policy 11-71, 2017.

[64] Facility Policy 11-71, 2017.

Issue 3: Inpatient Mental Health Services

One-to-One Care

The OIG substantiated that inpatient mental health unit staff did not consistently follow the facility's PSO policy outlining one-to-one care.[65] The OIG reviewed 16 patient cases with 315 incidents of one-to-one care during January 2017, and found several issues:

- PSO to patient ratios was not one-to-one.
- PSOs did not maintain constant visual observation of patients.
- A new order for one-to-one care was not documented every 24 hours by an LIP.
- Behaviors observed were not documented every 15 minutes on the facility flowsheet and scanned into the EHR as required.

Per facility policy, when a provider orders one-to-one care observation and a PSO is assigned to the patient, "at no time does the PSO leave the patient unattended or unobserved."[66]

The OIG found that PSOs were assigned to care for more than one patient with one-to-one observation orders. Staff reported that up to four patients with one-on-one observation orders may be moved together in a room with one PSO at night. During the day, patients with an assigned PSO were often left in the dayroom with the one staff member who was assigned to monitor the day room. Staff reported this typically occurred with patients who were at risk for falling or were using medical equipment for health conditions.[67]

If a PSO or other staff member was assigned more than one patient with one-to-one observation requirements, constant visual observation could not be maintained if a patient left the observation area. Interviewees told the OIG team that the assigned PSO would use the call light to alert other staff that assistance was needed in monitoring if patients with one-to-one orders left an area and the PSO could not accompany them. Should the PSO in the day room need to attend to a patient with immediate or personal needs, the other patients would be left unattended. When a patient is no longer in sight of a PSO or the PSO has multiple patients to monitor, the potential for patient harm arises.[68] The OIG observed PSOs who were not in close proximity of the assigned patient making it difficult to maintain constant observation as required by policy, and who were using personal cell phones when with the assigned patient.[69]

[65] Facility Policy 118-10, *Patient Safety Observer*, April 30, 2015.

[66] Facility Policy 118-10.

[67] Medical equipment included compression stockings or breathing machines that had connecting hoses between the machine and the patient; constant observation was required as the stockings or hoses could be used for strangulation.

[68] Facility Policy 118-10.

[69] Facility Policy 118-10.

Due to staff concerns of PSO care failing to prevent injury to patients, the OIG reviewed the facility inpatient mental health unit's patient incident log from January 1, 2017, through April 30, 2017, and found eight falls occurred when PSOs were assigned for patients considered high risk for falling. The OIG did not find evidence of significant injury to the patients.

The facility's PSO policy requires a new order for one-to-one observation care every 24 hours and documentation of behavior observations on a PSO flowsheet every 15 minutes; the flowsheet is subsequently scanned into the patient's EHR. Mental health leaders and staff could not consistently describe the documentation process for PSO one-to-one observation care. Orders for one-to-one care were not present in three EHRS of the 16 patients reviewed. PSO flowsheets for the 16 patients were either not completed or not scanned into the EHRs.

Alleged Inadequate Staffing

The OIG was unable to determine whether nurse staffing was adequate to meet patient care needs. The staffing methodology documents that the facility provided in 2017 were not complete and did not include PSOs who were assigned to mental health patients and assisted with patient care.[70] At the time of the 2018 OIG visit, the inpatient mental health unit (5C/5D) was separated into two distinct units. Patients with dementia were admitted to 5D (and not 5C). A geriatric psychologist was newly assigned to 5D. The staffing methodology documents provided in 2018 did not include supporting data used to determine NHPPD in the two distinct units with all dementia patients being placed on 5D.

In 2017, facility staff reported significant changes to the unit including a need to increase staffing when patients with dementia were admitted to the unit. Facility managers did not provide OIG with a completed revision of the unit's staffing methodology that included these changes. The staffing methodology information that was available for OIG's review reflected the first two quarters of FY 2017 and noted the need for more PSO staff, in part, because the patients with dementia who were increasingly being admitted to the mental health unit, often had more complex and/or greater personal care needs. Although the OIG requested staffing methodology for the most recent year completed, the information provided did not include a full year of data as required, nor did it include PSOs who were providing personal care.

According to VHA policy that was current at the time of OIG's 2017 visit, one-to-one sitters who only observe (that is, do not provide care) were excluded from staffing methodology calculations.[71] At the facility, PSOs provided more than observation during one-to-one care.[72] The OIG did not find evidence that the facility considered whether PSOs needed to be included in the mental health staffing methodology, which may have caused incomplete forecasting for

[70] VHA Directive 2010-034.

[71] VHA Directive 2010-034.

[72] Facility Policy 118-10.

the number and skill of staff needed per nursing hours of care per day. It is unclear how this impacted patient care because the OIG could not determine the needs of the unit based on historical data and staffing methodology. The staff reported that overtime was used often to accommodate patients who needed a PSO.[73]

At the time of the 2018 OIG visit, the inpatient mental health unit was separated into two distinct units. Patients with dementia were admitted to 5D (and not 5C). A geriatric psychologist was newly assigned to 5D. The OIG requested additional staffing methodology information.

Mental Health Training

The OIG substantiated that some staff who worked on the inpatient mental health unit did not have required training identified by the facility's Workplace Behavioral Risk Assessment in accordance with the facility's policy that was issued in 2012 and was current at the time of the events discussed in this report. Facility managers informed OIG inspectors in 2018 that they had adopted a two-year competency skills assessment requirement that had been approved in a 2013 Acting Deputy Under Secretary for Health for Operations and Management memorandum. The facility updated its 2012 policy in June 2018 to reflect the biennial requirement.[74]

PMDB

VHA requires all staff to complete Level 1 training once, within 90 days of hire and those who regularly and occasionally work with patients on the inpatient mental health unit complete training appropriate to their role and level of interaction with patients.[75] The facility's 2012 policy stated that "[s]upervisors will assign and ensure employees complete annual PMDB Training based on the risk level suggested by severity and frequency of behavioral incidents in the Annual Workplace Behavioral Risk Assessment."[76] The facility's FY 2016 work place behavioral risk assessment suggested a high level of risk for those staff working on the inpatient mental health unit, thus requiring PMDB training levels II, III, and IV annually under the facility's 2012 policy.[77]

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[73] VHA Directive 2010-034.

[74] Facility Policy Memorandum 00-32, *Workplace Safety and Facility Behavioral Response Programs,* June 6, 2018; Acting 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 Behavior (PMDB) Curriculum," November 7, 2013.

[75] Acting Deputy Under Secretary for Health for Operations and Management Memorandum, 2013; VHA Handbook 1160.06.

[76] Facility Policy 00-32, *Workplace Safety and Facility Behavioral Response Program*, December 20, 2012.

[77] Facility Policy 00-32; Facility FY16 Workplace Behavioral Risk Assessment.

In 2017, the facility provided the OIG team a list of staff assigned to the inpatient mental health unit.[78] The OIG determined that a majority of staff were not in compliance with the facility's requirement for annual PMDB training.

In May 2018, the OIG requested additional information regarding PMDB training for inpatient mental health staff. Although the facility had not amended its 2012 written policy, the facility informed the OIG that facility managers had adopted the 2013 Acting Deputy Under Secretary for Operations and Management recommendation to check PMDB competency skills every two years and if competency was inadequate, training was to be completed. The OIG team re-reviewed the PMDB mental health training information provided in 2017 and compared the information with the new data provided in 2018. The new staffing information did not match, and OIG was unable to determine whether staff who worked on the 5C/D combined unit in 2017 met either the annual training requirement or the biennial competency skills assessment requirement.

The OIG concluded that the inconsistency between practice and policy prior to issuance of the June 2018 policy may have caused confusion as to when training was required. Staff who do not have up-to-date skills or training may not be properly prepared to identify disruptive situations, recognize the signs that a disruptive situation could escalate to violence, and master their own personal responses, empowering them to intervene appropriately to reduce risk of injuries to self and others.[79]

Seclusion and Restraints

The OIG team requested and reviewed the restraint and seclusion records for the nursing staff assigned to the inpatient mental health unit (5C/D) in May 2017. Six (6.98 percent) of the 86 nursing staff assigned to the inpatient mental health unit had completed up-to-date training that was compliant with the facility's seclusion and restraints annual training requirement. When staff are not trained and competent in the use of restraint and seclusion, they may not be able to recognize the proper use of restraints or seclusion and may not ensure their safe use.[80]

Dementia Care

CMS offers Hand in Hand training to ensure staff caring for patients with dementia have tools and education needed to emphasize person-centered care and prevent abuse.[81] After a

[78] The list included 86 nurses, 2 social workers, 5 psychiatrists, 2 medical support assistants, 3 pharmacists, 5 nursing leaders, 2 physician assistants, and 54 staff members who occasionally worked on the unit.

[79] https://www.publichealth.va.gov/about/occhealth/violence-prevention.asp. (The website was accessed on April 19, 2019.)

[80] Facility *Restraint and Seclusion Policy,* No 11-17, March 1, 2017.

[81] Centers for Medicare & Medicaid Services, *Hand in Hand: A Training Series for Nursing Homes*, December 2012.

January 2015 visit and recommendation from VISN 18 Geriatrics and Extended Care program staff, facility leaders agreed that mental health staff should receive training related to the care of patients with dementia along with the CLC staff. Training for mental health staff was reportedly completed in January 2016. The OIG team reviewed the facility's action plan for the January 2015 VISN 18 Geriatrics and Extended Care Program Manager site visit, which indicated that mental health nursing staff completed the training on January 13, 2016. The OIG's review of training records provided by the facility revealed three (3.49 percent) of the 86 mental health unit nursing staff had documentation of completion of the training.

At the time of OIG's second visit in 2018, the facility explained to the OIG that a review of the CMS training revealed some inconsistencies with PMDB training. Additionally, the mental health unit had been separated into two distinct units with dementia patients being admitted to 5D only. Due to the first factor, facility managers halted the CMS Hand in Hand training and planned to provide dementia training that was more specific to mental health staff. This training had not been developed at the time of the OIG's second visit.

Therapeutic Environment

The OIG substantiated that the inpatient mental health unit was not a therapeutic environment at the time of the 2017 visit. The unit was not clean, the interior contained no visual appeal, patients did not wear personal clothes, a patient advocacy program was not in place, and individual psychotherapy was not readily available. At the time of OIG's 2018 visit, cleanliness was considered satisfactory, and facility leaders reiterated that staff were working on a procedure that would allow patients to wear personal clothes.

Cleanliness

In 2017, floors were dirty with rust stains throughout; trash cans were overflowing; bathrooms were dirty, odorous, and had moldy floors; and walls were patched without being re-covered with tiles. The OIG noted that one of the seclusion rooms, 5D-519, was not available for patient use for several weeks due to environmental issues.

Staff reported housekeeping services were not available on all shifts seven days a week. Facility leaders reported the mental health units did not have adequate housekeeping due to staffing levels.[82]

After the OIG's 2017 visit, facility leaders reported contracting with an external cleaning company. At the time of the 2018 visit, the floors and bathrooms were clean, and the unit's overall appearance was much improved, but updates had not been completed.

[82] VHA Directive 1908, *Comprehensive Environment of Care (CEOC) Program*, page 1, February 1, 2016.

Interior Updates

The unit's design was outdated without an open and inviting appearance as required by VHA's Mental Health Facilities Design Guide. The design and appearance of the unit did not promote health and recovery.

In 2017, the OIG discussed the outdated design of the inpatient mental health unit with facility leaders who provided a list of planned improvements estimated to be completed by September 2017. At the time of the 2018 OIG visit, improvements had not yet been implemented.

Personal Clothing

In May 2017, the OIG observed patients who were not wearing personal clothes; instead, they were all wearing facility pajamas. VHA Handbook requires all patients be allowed to dress in personal clothes during the day when it does not pose a safety risk.[83] The OIG team noted that previous reports from VHA leadership dating from July 2014 described a lack of personal clothing for patients. At the time of the 2018 visit, a mental health nurse leader reiterated that the facility was working on implementing a recovery model on the inpatient mental health unit including the availability of personal clothes.

Patient Advocacy Program

In May 2017, the OIG did not find postings of the telephone number for the service-level advocate or the facility's Patient Advocates. VHA Handbook requires this information be posted on all inpatient units in order to inform patients of the avenues available for the resolution of their complaints.[84] At the time of the 2018 visit, the OIG team also noted that facility managers had not posted the required information. Facility managers took action while the OIG team was onsite and posted the required information.

VHA Handbook 1003.04 required staff to resolve complaints at the lowest organizational level and instructed staff to inform: "patients who have unresolved complaints/concerns regarding the complaint process of options that are available to them" and to report "complaints resolved to the Service-level Advocate or in the absence of a Service Level Advocate, to the facility or Medical Center Patient Advocate for tracking purposes."[85]

The nurse manager for the inpatient mental health unit was the service-level liaison (patient advocate) responsible for receiving patient complaints from the staff, patients, or their families.

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[83] VHA Handbook 1160.06.

[84] VHA Handbook 1003.4.

[85] VHA Handbook 1003.4; VHA Directive 1003.4, which is currently in effect, states: "[a] patient advocate or service level advocate must enter a Report of Contact (ROC) in the patient advocate tracking system that consists of all contacts that have an issue to be solved. ROCs need to be resolved and closed within 7 business days."

The nurse manager informed the OIG about resolving nursing-care related complaints and coordinated with other departments to resolve non-nursing complaints. The nurse manager reported only logging complaints in PATS that could not be resolved. This practice was in accordance with the facility policy that allowed the service level advocate to use discretion to determine which personal contacts should be documented in PATS.[86] However, it was not in compliance with the VHA Handbook's stated goal of entering all complaints into PATS.[87] Incomplete data entry of patient complaints impedes VHA's ability to accurately trend, analyze, and use the data to improve patient experiences.[88]

Psychotherapy

While the availability of clinicians who could provide psychotherapy in the unit was low for several months around the time of OIG's first visit, the Section Chief of Psychology was available to make recommendations when necessary for outpatient psychotherapy. Additionally, a geriatric psychologist with expertise in the care of patients with dementia had been hired and was developing programs and training specific to patients with dementia joined the inpatient mental health staff in September 2017.[89] Therefore, the OIG did not make a recommendation related to availability of psychotherapy on the inpatient mental health unit.

Conclusion

The OIG did not substantiate that patients with current or historical documentation of known or suspected dementia were inappropriately admitted to the inpatient mental health unit. Admission criteria included patients with "[s]ymptoms of suicidality, homicidally [*sic*] or grave disability due to a mental illness, which includes mood, anxiety, and thought disorders."[90] The criteria included patients with dementia as long as the patient was medically cleared prior to admission. However, patients with dementia may have markedly different care needs from other patients admitted to the inpatient mental health care unit; the facility frequently addressed specific care needs of patients with dementia by using one-to-one observation.

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[86] Facility Policy 00-09, *Management of Patient Complaints, Compliments, and Inquiries*, June 21, 2013.

[87] VHA Handbook 1003.4.

[88] VHA Handbook, 1003.4.

[89] VHA Handbook 1160.06. One of the responsibilities of a facility's mental health service lead is to ensure "that the full range of mental health services is available to all patients on an inpatient mental health unit as appropriate to their clinical needs." The directive further states that "[s]ervices must include medication management, recovery-oriented services, family services, and evidence-based psychotherapies, as well as homeless services and evaluation for Therapeutic and Supported Employment Services (TSES) and Mental Health Intensive Case Management (MHICM). Programming on the unit must include individual, group therapy, psychosocial nursing education, as well as other services to meet individual patient care needs."

[90] *Facility Inpatient Psych Unit 5C 5D Admission Criteria*.

While the OIG team substantiated one of the two facility seclusion rooms was unavailable for several weeks in 2017 due to an environmental issue, the OIG was unable to determine whether a patient was improperly restrained because a seclusion room was not available. Staff told the OIG team about a patient who needed a seclusion room urgently and had to wait while a patient in the remaining seclusion room was moved and the room was cleaned and readied for use. To evaluate this issue further, the OIG team reviewed the EHRs of all six patients who had been placed in restraints and/or seclusion between January 1, 2017, through April 30, 2017. The OIG did not find evidence in the EHRs that patient care needs were negatively impacted due to the unavailability of a seclusion room. At the time of the team's 2018 visit, the second seclusion room was available for use. During its review of the six patients' EHRs, the OIG noted deficiencies related to consistent documentation of clinical justification for the continued use of restraints and debriefing sessions for the patient, staff, and family members after a restraint episode.

The OIG substantiated that inpatient mental health unit staff did not follow the facility policy for one-to-one patient safety observation. Staff reported and EHRs reviewed showed patients did not always have the individualized PSO care as required by facility policy. Multiple patients were placed together in one room at night with only one PSO when each had orders for a PSO. Additionally, during the day, multiple patients with one-to-one orders were in the day room with one PSO assigned to the day room.

The OIG was unable to determine whether nurse staffing was adequate to meet patient care needs. The staffing methodology documents that the facility provided in 2017 for the inpatient mental health unit 5C/D were not complete and did not include PSOs who were assigned to mental health patients and assisted with patient care. At the time of the 2018 OIG visit, the inpatient mental health unit was separated into two distinct units. Patients with dementia were admitted to 5D (and not 5C). The staffing methodology documents provided in 2018 did not include supporting data used to determine NHPPD in the two distinct units.

The OIG substantiated that some staff who worked on the inpatient mental health unit did not have required training identified by the facility's Workplace Behavioral Risk Assessment in accordance with the facility's 2012 policy that was current at the time of the events discussed in this report. Facility managers informed OIG inspectors in May 2018 that they had adopted the practice of a two-year competency skills assessment requirement although the 2012 facility policy indicated annual training was required. In June 2018, the facility rescinded the 2012 policy and officially adopted the two-year competency skills assessment requirement. OIG determined that the inconsistency between reported practice and the 2012 policy could have caused confusion related to training requirements.

The OIG substantiated that the inpatient mental health unit was not a therapeutic environment at the time of the 2017 visit. Floors and bathrooms were not clean, and patients were not wearing their own clothes. During the OIG's second visit to the unit, unit cleanliness was satisfactory but planned improvements had not yet been implemented. While the availability of clinicians who

could provide psychotherapy in the unit was low for several months around the time of the OIG's first visit, the Section Chief of Psychology was available to make recommendations when necessary for outpatient psychotherapy. Additionally, a geriatric psychologist reportedly joined the inpatient mental health staff in September 2017.

The OIG substantiated that nursing staff did not document patient complaints in the PATS. The nurse manager was the designated service-level advocate and although the nurse manager was following the facility policy, the facility policy was not consistent with VHA requirements.

Recommendations 1–7

1. The Phoenix VA Health Care System Director verifies that clinicians document clinical justification for the continued use of restraints and debriefing sessions according to Veterans Health Administration and Phoenix VA Health Care System policy requirements.

2. The Phoenix VA Health Care System Director makes certain that the Phoenix VA Health Care Patient Safety Observer policy is followed, and compliance is monitored.

3. The Phoenix VA Health Care System, Director ensures that inpatient mental health unit nurse staffing methodology is conducted as required by Nurse Staffing Methodology for Veterans Health Administration Nursing Personnel Directive.

4. The Phoenix VA Health Care System, Director confirms that mental health staff receive mandated training at required intervals including training for patients with dementia as appropriate, and compliance is monitored.

5. The Phoenix VA Health Care System Director verifies that the inpatient mental health unit is cleaned on a regular basis and compliance is monitored.

6. The Phoenix VA Health Care System Director ensures that the environment on the inpatient mental health unit is a home-like therapeutic setting as required by Veterans Health Administration Inpatient Mental Health Services Handbook.

7. The Phoenix VA Health Care System Director ensures that Phoenix VA Health Care System staff enter complaints into the Patient Advocate Tracking System consistent with current Veterans Health Administration Patient Advocacy Program and facility policies and compliance is monitored.

Appendix A: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: February 13, 2019

From: Director, Desert Pacific Healthcare Network (10N22)

Subj: Healthcare Inspection—Inpatient Mental Health Clinical Operations Concerns at the Phoenix VA Health Care System, Arizona

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

1. I have reviewed and concur with the findings and recommendations in the OIG report entitled Healthcare Inspection—Inpatient Mental Health Clinical Operations Concerns at the Phoenix VA Health Care System, Arizona.
2. For any questions, feel free to contact me at (562) 826-5963. Thank you.

(Original signed by:)

Michael W. Fisher
VISN 22 Network Director

Appendix B: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: February 13, 2019.

From: Director, Phoenix VA Health Care System (644/00)

Subj: Healthcare Inspection—Inpatient Mental Health Clinical Operations Concerns at the Phoenix VA Health Care System, Arizona

To: Director, Desert Pacific Healthcare Network (10N22)

1. Thank you for the opportunity to review and comment on the draft report, Healthcare Inspection- Phoenix VA Healthcare System (PVAHCS) Inpatient Mental Health Clinical Operations Concerns.
2. Regarding the title of this report, my understanding of the site visit was to address Human Resources concerns that were staffing related and not clinical concerns. Therefore, the following title would better reflect the intent of the site visit. "Healthcare Inspection-Phoenix VA Healthcare System (PVAHCS) Inpatient Mental Health Management Review".[91]
3. Since the initial site visit in May 2017, our Phoenix team immediately began working on resolving the recommendations. Therefore, at this time, I would like to recommend closure on all findings based on the attached evidence.
4. If you have any additional questions, please contact me at (602) 277-5551 ext7891. Thank you.

(Original signed by:)

RIMA ANN O. NELSON
Medical Center Director

[91] The OIG reviewed the engagement letter sent to the facility to announce this inspection. It stated "[t]he purpose of this visit is to assess the merit of allegations made about the clinical operations of the acute care mental health unit." The OIG determined that the current title accurately reflects the purpose of the visit as explained in the engagement letter, in discussions with leaders and staff when on-site, and through documents requested and reviewed throughout the inspection.

Comments to OIG's Report

Recommendation 1

The Phoenix VA Health Care System Director verifies that clinicians document clinical justification for the continued use of restraints and debriefing sessions according to Veterans Health Administration and Phoenix VA Health Care System policy requirements.

Concur.

Target date for completion: Open

Director Comments

The criteria for restraint usage, documentation and debriefing requirements are defined in the revised facility Restraint and Seclusion Policy, June 2018. To assess compliance, restraint episodes have been tracked. Data from June 2018 – December 2018 reveal 100% (10/10) compliance with documentation of the clinical indication for the restraint usage. Additionally, debriefing occurred for 10/10 (100%) restraint or seclusion episodes, in accordance with the facility policy. The revised policy (June 2018) does not require documentation of the debriefing discussions, but that these occur. The revised policy and evidence of compliance are attached. Request closure on final draft.

OIG Comment

The OIG considers this recommendation open.

Recommendation 2

The Phoenix VA Health Care System Director makes certain that the Phoenix VA Health Care Patient Safety Observer policy is followed, and compliance is monitored.

Concur.

Target date for completion: Completed

Director Comments

In review of the 1:1 status of patients, and the use of Patient Safety Observers (PSO) or companions, the facility found that some patients were identified as requiring PSOs when the clinical indications were for companions. According to facility policy, a 1:1 Patient Safety Observer (PSO) is placed with a patient for their safety when experiencing thoughts of suicide, homicide or behaviors that threatens the general safety/milieu of the units. A companion observer has a different function – most often assigned for safety i.e. reduce falls risks or assist with protection of medical devices but may be assigned to more than one patient to monitor. The

PSO order is to be renewed daily. There is no daily order renewal requirement for the companion. Indications are that the appropriate level of care was provided, the but renewal of orders was inconsistent. To ensure consistent documentation, the service will complete a monthly audit that includes PSO observations (five per month) while engaged in observation of 1:1 status to ensure compliance with the Patient Safety Observer Policy is maintained for a period of three consecutive months. The tool used for January 2019 and February 2019 (to date) is attached.

To address scanning, a sample chart review of the five records per month January to December 2018, was completed (n=58). Although some months are below 90%, the data revealed 100% compliance with PSO documentation scanned into the record August 2018 – December 2018, 5 consecutive months of sustained outcomes. The audit is attached. Based on data and plan, requesting closure on final report.

OIG Comment

Based on information provided, the OIG considers this recommendation closed.

Recommendation 3

The Phoenix VA Health Care System Director ensures that inpatient mental health unit nurse staffing methodology is conducted as required by Nurse Staffing Methodology for Veterans Health Administration Nursing Personnel Directive.

Concur.

Target date for completion: Completed

Director Comments

Staffing methodology is completed in accordance with VHA Directive 1351. The Inpatient MH units completed staffing methodology (SM) in May 2018, considering all care needs. The attached SM worksheets for the two inpatient MH units demonstrate a staffing allocation consistent with the staffing recommendations from the SM worksheet. The positive variance between the staffing requirement and ceiling allows the flexibility to redirect assignments based on the clinical needs of the shift. To further document the consideration of companions and PSOs into the SM for the Inpatient MH units, a retrospective analysis of the hours for companions and PSOs was completed. The hours used were converted to FTE to ensure staffing resources were allocated (attachment- 5C5D PSO Companion Hours). These FTE are noted in the staffing methodology calculator for each unit (attached – Jan 2019). The FTE used July 2018 – January 2019 were 2.14 FTE and 4.88 FTE for unit 5C and 5D respectively. The Nursing Assistant and LPN FTE available in the staffing ceiling include these FTE (See SM calculator for 5C and 5D). Both inpatient MH units show a positive variance in overall staffing allocation. While the

variance for Nursing Assistants and 5D reflects a 2.4 FTE deficit, 5C has a positive 2.3 variance allowing staff to be assigned to cover clinical needs on 5D, as they occur.

As part of SM, the hours per patient day (HPPD) were determined for each unit, with a 10% variance. A review of the HPPD average by month for each inpatient mental health unit is attached, indicating staffing resources consistent with the HPPD recommendations from SM for 10 of 12 months. Request closure on final report with this additional clarification for recommendation.

OIG Comment

Based on information provided, the OIG considers this recommendation closed.

Recommendation 4

The Phoenix VA Health Care System Director confirms that mental health staff receive mandated training at required intervals including training for patients with dementia as appropriate, and compliance is monitored.

Concur.

Target date for completion: Open

Director Comments

The PVAHCS Mental Health staff has completed training on Dementia. The training was completed by a nurse educator and through the Talent Management System (TMS). There is 100% compliance with the training. The training courses are as follows:

- VA 15873 – Start making sense: How to communicate effectively with Veterans with Dementia.
- NFED 13745 Dementia care I, mental decline and caregiving challenges
- NFED 13746 – Dementia care II, Physical decline and caregiving challenges
- NFED 13747 – Dementia care III, Understanding & managing difficult behavior to include both the indications for use as well as application of restraints.

In-service by the Unit Based Nurse Educator was provided to all staff. Request closure on final report.

OIG Comment

The OIG considers this recommendation open.

Recommendation 5

The Phoenix VA Health Care System Director verifies that the inpatient mental health unit is cleaned on a regular basis and compliance is monitored.

Concur.

Target date for completion: Completed

Director Comments

The PVAHCS has continued focus on the area for sustainment through the "Keep it Clean" program. This program engages staff and leaders by providing clear expectations of cleanliness and creates a healthy competitive spirit with rewards and recognition. Environmental Management Service (EMS) has also initiated team huddles to ensure a cohesive approach to maintaining cleanliness. A representative from EMS and a representative(s) from the inpatient MH nursing team, to include nurse managers or chief nurse, round weekly. These rounds are to assess the environment for cleanliness and to address engineering needs. If the findings are not able to be addressed in real time, work orders are initiated. Examples of the calendar invitation, observations from rounds in July and August and staff communication are attached.

To sustain the cleanliness and improve teamwork, additional EMS staff have been assigned to cover the inpatient MH units, in January 2018. During the 2018 OIG visit, the reviewers found "the floors and bathrooms were clean, and the unit's overall appearance was much improved, but the updates had not been completed." The status of the updates is addressed Recommendation 6. Request closure based on sustained efforts and sustainment process in place for the final report.

OIG Comment

Based on information provided, the OIG considers this recommendation closed.

Recommendation 6

The Phoenix VA Health Care System Director ensures that the environment on the inpatient mental health unit is a home-like therapeutic setting as required by Veterans Health Administration Inpatient Mental Health Services Handbook.

Concur.

Target date for completion: Open

Director Comments

PVAHCS recognized that the Inpatient Mental Health Units were due for updates and modifications. The Unit has completed a replacement of 100% of the inpatient beds and mattresses. The showers have also been renovated to include shower stall upgrades with new

fiberglass inserts, new flooring and new fixtures. Rooms were painted and brightened, and the hall walls have been painted. The package that has been developed, submitted to contracting and is awaiting solicitation includes replacing flooring in halls, patient rooms and restrooms inside the patient rooms, replacing sink fixtures in the patient restrooms, replacing toilets, replacing tile and wall coverings in restrooms inside the patient rooms. Documentation is attached to include funding for inpatient MH renovations.

To further address the homelike environment, there has been education and emphasis on the Recovery Model, to include Veterans wearing their own cloths [*sic*]. Voluntary service provides clothes for those who need. Individual Veteran progression and participation in the Recovery Model was discussed are attached, along with an example of an email forwarded to staff. Staff education on the Recovery Model is also attached (two Nurse Managers are listed but excluded). Request closure on final report with the completed work, and obligations and plan for remaining improvements. See evidence for Recommendation 6.

OIG Comment

The OIG considers this recommendation open.

Recommendation 7

The Phoenix VA Health Care System Director ensures that Phoenix VA Health Care System staff enter complaints into the Patient Advocate Tracking System consistent with current Veterans Health Administration Patient Advocacy Program and facility policies, and compliance is monitored.

Concur.

Target date for completion: Completed

Director Comments

In accordance with the Functional Statement, the Nurse Manager is responsible for performance improvement data, customer service/patient satisfaction, patient and employee safety, interviewing applicants, employee relations, standards of care and practice, the work environment, and accreditation and regulatory standards. In this role, the Nurse Manager responds to and addresses patient/family member complaints, which is consistent with the facility policy. Patient Advocate signage with contact information has been posted in each day room so Veterans may contact the Patient Advocate directly.

VHA Handbook 1003.2 identifies various stages of service recovery. Stage 1 is outlined as the identification of an opportunity to correct and unmet service expectation, and stage 2 underscores a resolution of the problem. The handbook allows the management of issues and complaints at the front line, resolving the concerns, and, alleviating the need for involvement of the Patient

Advocate (Section 7, STAGES OF SERVICE RECOVERY). The Nurse Manager is the first-line Advocate for the Veteran and communicates with the Patient Advocate to have information placed in the PATS system. The attachment documents a total of 47 PATs entries January – December 2018. Updates are communicated in unit huddles regarding trends or concerns as they relate to an area. Request closure on final report with the clarification of the process. See evidence for Recommendation 7.

OIG Comment

Based on information provided, the OIG considers this recommendation closed.

OIG Contact and Staff Acknowledgments

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